State of Maryland / Department of Health and Mental Hygiene 2.0.0

Physicia /Medic Examin

Funeral Director

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exprised must be rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	Otato or mary	Ce	rtificate of Death		Reg. No.	00	28501
	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death
n al	Louisa M. C	Crist		,	Aug.	12 2	005	2:25 A
er	4a. Facility Name (If not institution, give s			4b. City, Town, or Location of	Death	4c. County		
	2000 Blacks Sch			Westminster		Carr		
	5. Social Security Number 6. Sex 183-18-7480	7. Age (In	yrs. last birthday) Q4 Yrs.	If Under 1 Year	Hrs. 8. Date of Bir (Month, Da Apr. 2	th y, Year)	9. Birthpl.	ace (State or Foreign ry)
	Usual Residence of Decedent		94		Apr. Z	0,1911	PA	
	10a. State 10b. County		c. City, Town or Lo	Westminst	ar		10	d. Inside City Limits
ţo	MD Carrol	11		Westmins	.er			1 ☐ Yes 2 No
ïře	10e. Street and Number			10f. Zip Code		10g. Citizen of V	Vhat Count	try?
a	2000 Blacks Sch	noolhouse	Rd.	21158			USA	
Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	? (Specify Yes or No	- 14. Rac	e - America k, White, e	
	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 ☐ No Specify:	20110 1 110411, 0101,	Specifi		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ם ס	3 ₩Widowed 4 Divorced	Year or Dates:					wh	ite
Completed by	15. Decedent's Edu (Specify only highest grade		16a. Dece (Give	dent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	16b. Kind of Bi	isiness/Ind	ustry
Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		mstress		Commission	Eco	~ ~ ~ ~
	17. Father's Name (First, Middle, Last)		_ Beal		Name (First, Middle	Sewing Maiden Suman		LOLY
o Be	John Cron	ne.		S:	san Lefe	ver		
-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street and Number			State, Zip	Code) 21158
	Judy Bollinger	/ Daughte		O Blacks Scho				
	20a. Method of Disposition		Ob. Place of Dispo	osition (Name of matory or other place)	Date	20c. Location -	City or Tov	wn, State
	1 ☑Burial 2 ☐ Cremation 3 ☑ R 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State		Lischey's Cemeter,	8/17/0	Sirin	o Gr	cve.P:
	21. Signature of Funeral Service Licens			2. Name and Address of Facility			17	340
	1 - Gilande	JAHO.	A L	ittle's F.H.	34 Meple	1.70	Litt	lestown,
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	tions that caused the	th. Do not en	ter the mode of dying, such as ca	rdiac or respiratory a	rrest,	1	Approximate Interval Between
	Immediate Cause (Final disease or condition	A	0. 1	10. 110	7 -			Onset and Death
	resulting in death)	Die to (or as a co	nsequence of):	Vascular	usease		9	25 grs
	Coguantially list conditions	Cerebra	viscul	in accident	7			10 mas
ner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a eo	neequenes of):					
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	advor	reed t	ije				
	resulting in death) cast	Due to (or as a co	nsequence of):	1				
edicai		J			···-			
≥	IF FEMALE:	23a If you cuttoome of pu	0000000					
ian,	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1☐Live birth 2☐	Fetal death 3	Ectopic pregnancy		23d. Da	e of delive: nth	ry Day Year
ysic	1 ☐ Yes 2 € No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	ordeath 5L	Other (specify)				
by Physician/	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	inderlying cause given in Part I.	23e. Did t	obacco use cont	ribute to the	e cause of death?
					1 🗀 '	Yes 2 No	3 🗌 Proba	ably 4 Unknown
ompieted					24a. Was	24h 1	More suter	ou findings quallable
E E					— autoj	osy	rior to con leath?	sy findings available apletion of cause of
CC	25. Was case referred to medical				1 Tes	2 No	Yes	2 □ No
20	examiner?	fospital:	2 ER/Outpatier	Other	ng Home 5 esi		/Ci4	
=	27. Manner of Death	28a. Date of Injury (Month, Day Yea		f 28c, Injury at	1997	now injury occur	er <i>(Specify</i> ed)
i i	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury	Work? M 1 ☐ Yes 2 ☐ No				
1108	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, st	reet, factory, office	28f. Location (Street and Numb	er or Rural	Route Number,
ert	4 Homicide	building, etc. (S	pecify)		City or To	vn, State)		
ai	29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, deat	h occurred at the time, date and	place, and due to the	cause(s) and ma	nner as sta	ated.
Medical Certification: 10	(Check only 2 Medical Examination)	ner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my opinion, death	occurred at the time,	date and place,	and due to	the cause(s)
Ž	29b. Signature and title of certifier			29c. License number		29d. Date signe		
	1/ m 1/ m	riddl.L.	mo	D25443 Ede Road M		8/15	120	05
	30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print)		2,.9	, -0	
		11.21	ma a	1 0 . 11	4 1 .		4 5	
-	John W. Whide	CULTON (88 10	de Road M	estan in	tor .	MD.	21157

State Registrar

05-05708 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alfred J. Depaolis State of Maryland / Department of Health and Mental Hygiene 205 tas For Amend Item 1&Unpend Item 23a&2/ per me G84/9-22-05 tas Registrar item #10c, per/f.h, 8/25/05; ertificate of Death WCHD, E.T Reg. No. 28502 Amended 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 23 2005 2005 **Physician** 1827 P. M JAMES DEPAOLIS, JR. ALFRED /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Penninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 13, 1 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 74 1931 Washington, 214-32-8302 Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits wohe in than "naturel", or iteme 23s or 28s-f ehor the Medical Examinar must be notified at Pocomoke-City Pocomoke City 1 Yes X No Director MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2227 Worcester Highway 21851 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Maritaf Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Maintenance Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental H 7 is marked ot treumatic (unknown) Alfred James DePaolis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Depertment of Health ar Importent: If Item 27 is eny Injury or other treu 2227 Worcester Hwy., Pocomoke City, MD 21851 Michael DePaolis (nephew) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 8/25/2005 Salisbury, MD 21. Signature of Funeral Pervice Licenses 22. Name and Address of Facility Holloway MElson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 Zean Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 1 XYes 2 □ No Physician: ofter death.

Director: After this certific in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospitaf: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 XYes 2 No 27. Manner of Death 1 A Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli ca 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending 24 hours e within 24 ho To the Functional To the

29b. Signature and title of certifier O.C.M.E.

and manner stated

29c. License number 29d. Date signed (Month, Day, Year) August 24, 2005

30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 21201 RUBIO 10

31. Date filed (Month, Day, Year) State AUG 2 6 2005 Registrar

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2005 28503 1 - For State Registrer Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Robert Reid Donithan, Jr. 9:23 a M 16, August 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Westminster Nursing & Rehabilitative Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 27, 1928 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex Hours **Funeral** 1√2 M 2□ F Maryland 76 217-24-1891 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show item 27 is marked other then "natural", or items 23e or 28a-1 shov other traumatic event, the Medical Examiner must be multified at Hampstead 1 ☐ Yes 2 XNo Director Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number WITH 21074 4353 Sycamore Drive death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or iter ☐Yes 2☑No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2√ No Specify: white Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Iron Workers Union Iron Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert R. Donithan, Sr. Mary Higgs 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 445 Hand Court, Hampstead, MD 21074 portment of Health a portant: If item 27 is y injury or other tra Ken Donithan, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 08/17/2005 Carroll Cremations Hampstead, MD A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00723 Eline Funeral Home Depart any in 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 YEARS nen /Medical Due to (o as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 2□ No certificate 1 ☐ Yes 2 No 1 🗆 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifier MSL DO059552 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLE RD WESTMINSTER 700A GOURISHANKAR MOANNA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 7 2005 Elem & Sperte Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 28504 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Thurman Davis, Sr. 8 2005 3:50 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Charlotte Hall St. Mary's Charlotte Hall Veterans Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 🙀 M 2 🗆 F Director 240-20-4515 2-12-1922 South Carolina Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-1 show the Medical Examinar must be notified at 1 ☐ Yes 2 € No St. Inigoes Maryland St. Mary's Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20684 17403 Mt. Zion Church Road United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No 1943− If Yes, Give Year or Dates: 1945 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examina 2008. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: Black þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Boiler Attendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Lou Davis Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17403 Mt. Zion Church Road, St. Inigoes, MD 20684 Mary Ann Briscoe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State First Missionary Bapt 8-27-2005 Lexington Park, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun and Service Licens 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran NOTO P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes → No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 1 Yes 2 No Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this the funeral Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death After Natural 5 Pending 2 🗆 No after death. investigation 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ 0 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 29449 Charlotte Hall Road, Charlotte Hall, Maryland 20622 Manaj Mathur, 31. Date filed (Month, Daf AUG 2 4 20 05 32. Regis State Registrar

			1 - For State Registrar	State of	Maryland	-			ealth a Death	and M		gienę Reg. Na	200	5	28505
	Physici	an	1. Decedent's Name (First, Middle, L.								2. Date of Dea Month	ath Day 18	Y	e <u>a</u> r	3. Time of Death
	/Medic	al	HERMAN EDWAR 4a. Fecility Name (If not institution, gi		GLOFF		4h City	Town or	Location o	of Death	AUGUST		, 200 County of I		1155 м
	Examin	ier	13155 Little Ha				40. O.ly		lagers		ı				hington
	Funeral				7. Age (In yrs. la	•	If Under	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Day	y, Year)	9.		lace (State or Foreign
	Director		209-14-3557 Usual Residence of Decedent	IAIM 50 F	78	Yrs.					JULY 9,	192	27]	PEN	NSYLVANIA
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
	8a-f st	Director		SHINGTON					AGERS	TOWN					1X7Yes 2 ☐ No
	th with th		13155 LITTLE HA	YDEN CIRC	CLE		10f. Zip	Code	21742	2		10g. Citia	zen of Wha	U.S	•
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "natural; or items 23s or 28s-f show or other traumatic event, the Medical Ereth art man ke notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed For	² □№ 194	5-	Was Dece I Yes, spe 1 Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)		14. Race - Black, 1 Specify:	White,	
15-0036	in 72 hou	Completed	15. Decedent's I (Specify only highest g	rade completed)		16a. Dece		rk done d	turina most	t of worki	ng	16b. Kir	nd of Busin		
2121	filed within Hygiene. other then ont, the Mer	om	Elementary/Secondary (0-12)	College (1-	-4or 5+)	SALES	& SE	RVIÇ	ES RE	PRES	ENT.	INDU	JSTRI.	AL :	FINISHES CO
	be filed ital Hygi id other	Be	17. Father's Name (First, Middle, Las								(First, Middle,		Sumame)		
Maryland	should be and Mental is marked o sumatic eve	٦°	GEORGE A. EGLOFF			19b. Maili	na Address	s (Street a			KETTERI		r Town, Sta	ate, Zip	Code)
	alth an 27 is ar trau		BEATRICE B. EGLOF		j						RCLE, H				
3altimore,	ges 1 and 2 it of Health if item 27 or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from S	1 00	lace of Dispo emetery, crea	sition (Name	me of other plac	Θ)	C	ate	20c. Lo	cation - Cit	ty or To	own, State
ţ	Ly in Pa	Ì	' 4 ☐ Donation 5 ☐ Other (Spec	ity)		NSBOR					2005			-	MARYLAND
Bal	permit. Departrimports any inju		21. Signature of Fureral Service Lice	(- Zimmer	В			AI HO		7606 01 Boonsbo				
	E UNI		23a. Intl. Enter the discase, or conshoot of eart fail ine. List on				er the mod	de of dyin	g, such as	cardiac c			Hary.	Latt	Approximate Interval Between
	Physician	П	Immediate C use (Final disease or condition	2	Cong	iestiv.			feith						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	ence of):	Tone	cic	1					T	J. earl
		Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	,	10110	1.0							y torrs
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /	or as a consequ	onary	ar	lery	1 11	sca	se ·				years.
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.O. Box	the death certifice / the attending pr ched for use as t	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown		irth 2 ☐ Fetal ant at time of de	death 3[∃Ectopic p ∃ Other <i>(s)</i>					2	23d. Date o Month		ery Day Year
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Re	9 4 8	omb		(1)/200	10017	1						osy rmed? 2 ∑∜ No	dea	ıth?	mpletion of cause of 2 No
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o		-		
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ion	nding ath. r: Afte e fune	atlon	1 Natural 5 Pending 2 Accident investigat	(Mont	h, Day Year)	Injury	М	Wor	k? Yes 2□	No					
Division of Vital Records,	i or Atte efter dez Director	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be d 28e. Place buildin	of Injury - At ho ng, etc. (Specify	ome, farm, st	reet, factor	y, office			28f. Location (S City or Tov			or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C		Physician: To the aminer: On the ba and mann	sis of examinat										
	To the vithin To the compl	Me	29b. Signature and title of certifier	11/			29		e number	,					Day, Year)
			10-	1		00-1	District	24	4990	0		1+0	19	18,	2005 MD 21713
5H-1	5+1		30. Name and address of person wh	o completed caus	e or death (item	(Type	Print)	16	ppa	ms	Rd 1	SUD.	nsbo	20	MD 21713
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32. R	gistrar's Signa	ture A. L	pule	,							

			For State Registrar	State of Marylar		artmen <i>rtificat</i>				giene Reg. No.	28506
			Decedent's Name (First, Middle, Last	st)					2. Date of Dea	ath	3. Time of Death
	Physici		James E	dward Fra	ancis				AUGUST	$19^{ay}, 2005^{ar}$	2:14 P M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of Death		4c. County of Dea	
1	Examili	eı	18521 HERRING CRI	EEK BD		ТΔТ	L TIM	(REDS		ST MARY	S CO
	Funeral		5. Social Security Number 6. S		last birthday)	If Under	r 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. Bi	rthplace (State or Foreign
	Director		230-54-2774	₽ M 2□F 62	Yrs.	Months	Days	Hours Min.	(Month, Day April 1		hington, DC
			Usual Residence of Decedent								
	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	Maryland St. Mar	y's		Tal	1 Tin	nbers			1 ☐ Yes 2 € No
	th th	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of What C	country?
	23a	a	18521 Herring Cre	ek Road			2069	_		United St	ates
	ep E	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Deced	dent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh	
98	or it		1 Never Married 2 Married	1 Yes 2 No If Yes, Give	1	1 🗆 Yes		Specify:		Specify: W	hite
8	72 hours after deeth with the Marylend Insture!', or iteme 23a or 28e-f ehow dies Esa olice frout be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			100 01		1		
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12	within ene. then "	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	<i>m</i> 6.	Teac	,			Educat	ion
2	lled lygi		17. Father's Name (First, Middle, Last)			reac		18 Mother's Nam	e (First Middle	Maiden Sumame)	TOIL
Maryland 21215-0036		Be	Charles Kenneth						t Ander	,	
Ž	es 1 and 2 should b of Heelth and Ment litem 27 le marked r other traumatice	ျှ	19a. Informant's Name/Relationship		10h Mailir	na Address	c /Stroot a			er, City or Town, State.	Zin Code)
Ma	d 2 s th an 17 le		Charles K. Franci		1						, , , ,
d)	1 and 2 Heelth a om 27 la		20a. Method of Disposition	20b. I	Place of Dispo	sition (Nai	me of		Date	20c. Location - City o	
و	nt of nt of or		1 Burial 2 Cremation 3	Removal from State	cemetery, crei	matory or c	other place		2005		
Baltimore,	Trant		4 Donation 5 Other (Specification 21. Signature of Fundamental Processing Services Description 21.		insfie			8-24-		Charlotte	
Ba	permit. Pages i Depertment of I Important: If the eny injury or ot		The su	ver -						d Funeral	· ·
		Н	23a. Part1. Enter the disease, or com	M0120							D 20650-0279
			shock, or heart failure. List only								Approximate Interval Between Onset and Death
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hyperium. Due to (or as a consec	in ati	LINOSC	pret	y lardi	Vascula	r discase	
	Examiner			Due to (or as a consec	quence of):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):						
	ted nsit	듄	cause. Enter Underlying Cause (Disease or injury		,						
	xecu and	Examln	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):						
8760,	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	<u>42</u>									
687	phys s the	dlcal	2 80	, d							
×	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn.						23d. Date of d	alivery
Вох	atter I for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic p				Month	Day Year
0	y the	ys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,,		-		
<u>a</u>	that the de led by the a detached		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the u	nderlying o	cause give	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?
g _p	ulres sign ld be	d by							1)2(1)	res 2□No 3□F	Probably 4 Unknown
Ö	w requ been shoul	ompleted							24a. Was	an 24h Ware s	utopsy findings available
Re	The lay	E G							autop	osy prior to	completion of cause of
a		O	OS Man anno referred to ma disal						1 /	rmed? death? 2 No 1 Ye	s 2 No
₹	ici ee Ge	o Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 □ No	Hospital:	3500		Othe	26. Place of Dear		1	· · · · · · · · · · · · · · · · · · ·
o			27. Manner of Death	1 Inpatient 2	28b. Time o		JA	4 🗆 Hursing ric		dence 6 X Other (Sp	ecity) SCENE
o	ding h. After funer	tou	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	28c. Injury Work 1 □ Y	? 'es 2 □No		,.,	
Division of Vital Records,	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not b	e 28e. Place of Injury - Al h	iome, farm, str				28f. Location (S	Street and Number or F	Rural Route Number.
5	after d Direct	Certification:	4 Homicide	building, etc. (Speci	fy)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tou	vn, State)	
	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune		29a, Certifier 1 ☐ Certifying Ph	ysician: To the best of my kno	owledge, deat	h occurred	at the time	e, date and place,	and due to the	cause(s) and manner a	is stated.
	E Fu	Medical		niner: On the basis of examina and manner stated.							
	To the Hoepitel or At within 24 hours after d within 24 hours after d . To the Funerel Direct completely filled in by	Me	29b. Signature and tille of certifier			290	c. License	number		29d. Date signed (Mor	oth, Day, Year)
	16		1 /6/ 4/180	lAC-			0 C I	ΜЕ		AUGUST 20,	2005
	9/		30. Name and address of person who	completed cause of death (Iter	m 23a) (Tvoa						
	5		ZARILICIAH	AU			ENN S	STREET, 1	BALTIMOR	RE, MARYLAN	D, 21201
	Sta Regist		31. Date filed (Month, Day, Year) 2	5 2005 Register's Sign	ature	de	رنگ				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2005 6:00 A August 18 Larry Eugene Giffin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Sharpsburg 16643 Shaffer Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Yrs Oct.14,1940 Maryland 64 Director <u>579-52-5114</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State ir than "naturel", or ltems 23a or 28e-f show the Medical Exaratrational be notified at 1 Yes 2XNo Sharpsburg Maryland Washington Direct 10g. Citizen of What Country? 10e. Street and Number With 21782 Funeral 16643 Shaffer Rd. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. fited within 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Refrigeration Equip. Foundry Worker permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Importent: If item 27 is marked other it, any injury or other treumatic event, this once. 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alice Ruth Stull Charles Edward Giffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21782 16643 Shaffer Rd. Sharpsburg, Maryland Doris L. Giffin - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Bakersville Cemetery Aug.22,2005 Boonsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Osborne Afrenerally Home, P.A. 21. Signature of Funeral Service 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 mont **Physician** Lolon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, Lauring to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 use as the attending p for use as 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No certificate Division of Vital To the Hospitel or Attending Physicien: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 27. Manner of Death Certification: Aftert Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 | Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 41667

SH-A

State 31. Date filed (Month, Day, Year)

Registrar

AUG 19 2005

Michae



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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redical Comes Hagerstown MD

	4	For State Registrar	State of Maryla	and / Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death		giene2	005	28508
Physicia	ın j	1. Decedent's Name (First, Middle, Last)	41	-			2. Date of Dea Month	Day	Year	3. Time of Death 7:35 A M
/Medic	- 3	Marı la. Facility Name (If not institution, give str	e Alice Hil	<u> </u>	4b. City, Town, or	Location of Death	August		unty of Death	A
Examine	ei Ž	29685 Three Notch 1			Charlot	te Hall		St	. Mary'	S
Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 8,	n /, Yea <i>r)</i>		lace (State or Foreign try)
pu .		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation				1	0d. Inside City Limits
Aarylan I show	ŏ									1 ☐ Yes 2XXNo
28a-	Director	Maryland St. Mary's 10e. Street and Number		Helen	10f. Zip Code			10g. Citizen	of What Cour	itry?
h with		29933 Point Lookout Roa	ıd		20635			USA		
should be filed within 72 hours after death with the Maryland and Mentyl Hygiene. The Hygiene 1999 is marked other than "natural", or items 23a or 28a-f show umatic event, if a Medical Examinar must be notified.	y Funeral	1 Never Married 2 Married	Nas Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: White	etc.
hours tural',	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educa	Year or Dates:	16a Deced	ent's Usual Occupa	ation			of Business/Inc	
permit. Pages 1 and 2 should be filed within 72 hours beatmen. Pages 1 and 2 should be filed within 72 hours beatment of Health and Mental Hygiene. Internal, important: If tem 27 is marked other than "natural, any injury or other traumatic event, tra Medical Exagnes.	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of work	ring		& Grocery	
filed y		17. Father's Name (First, Middle, Last)		Owner		18. Mother's Nam	e (First, Middle,			<u> </u>
Aental Mental rked o	To Be	William Albert Wood				Mary Alic	e Thompso	n		
2 shou and N ls man		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Street a	and Number or Rur	al Route Numbe	r, City or To	own, State, Zip	Code)
and 2 ealth m 27 her tra	,	Larry Duane Hill / Son	20	26722 b. Place of Dispos		ve, Mechani	csville,		nd 20659	uun State
Pages 1 nent of He int: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, cren	sillori (Name of natory or other plac s Cemetery	Au	gust		za, Maryl	
permit. P Departm Imports any injui		21. Signatore of Funeral Service Licensee		22 Ma	Name and Address	ss of Facility ardiner Fun	eral Home	, P.A.		
	-	23a. Part . Enter the disease, or complici shock, or heart failure. List only one	ations that caused the c			, Leonardto g, such as cardiac			550	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Ro.	wingle	DUFO,	lure				Opsat and Death
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cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cor	sequence of):						
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requir een si	ted	0 9		-			-			pably 4 □Unknown
The law sete has be page 2 sl	Completed	- VLAVERI					24a. Was autop perfo 1 Yes	rmed?	24b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
VII.aniicianii	Be	25. Was case referred to medical examiner?	ospital:		· all DOA Oth	26. Place of Dea				Daughter's %) Residence
Phys or this oral dii	: To	1 ☐ Yes 2, No 27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of	3 500	4 Li Nui skig i ii	ome 5 🖾 Resid			W Residence
r Attending Pr for death. lector: Atter th	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ir) Injury		k? Yes 2 □No				
ol or Atte s after dea I Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, stroecify)	eet, factory, office		28f. Location (S City or Tox		lumber or Rura	il Route Number,
e Hospit 24 hours e Funera letely fille	edical (29a. Certifier (Check only one)	cian: To the best of my er: On the basis of examination of examination of examples and examples are the control of the control	knowledge, death mination and/or in	n occurred at the tin vestigation, in my o	me, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. o the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier	Park	2 AM	29c. Licens	(0641	9	29d. Date s	igned (Month,	Day, Year)
		30. Name and address of person who con	11			d M1	20626			
Sta	te	James P. Jafboe, M.D. 31. Date filed (Month, Day, Year) AUG 2 4 200	24035 Three Legistrar's S		i, HOTTYWOO	u, maryland	20636			
Registr		MUG 2 4 200	D) Aire	A PA						

*	•	1	For State Registrer	State of Maryland		artment of H			giene Reg. No. 20 (05 28509
	siciar	1	. Decedent's Name (First, Middle, Las	HESS				2. Date of Dea	Day, Y	(ear 6:14 PM
Exa	edica mine	4	a. Facility Name (If not institution, give	street and number)	ast birthday)	4b. City, Town, or Hagersto			4c. County of	ngton County 3. Birthplace (State or Foreign
Fune: Direct			214-32-4711 Jsual Residence of Decedent	^{□ M 2} F 69	Yrs.	Months Days	Hours Min.		y, Year) 23, 1935	Maryland
e Maryland Ba-f show					, Town or Lo gersto	wn				10d. Inside City Limits 1 ☐ Yes 2√2 No
vith th	ä	ו ב	10e. Street and Number 825 Jefferson Bly	•A		10f. Zip Code 2174	0		U.S.A.	at Country?
DESILITIOTE, INIGITY IGILIC Z. I.Z. I.S. USSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tiem 27 Is marked or other than "natural", or Items 23a or 28a-1 show any injury or other transmits event the Medical Engine Institute or other		5	1. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)		American Indian, White, etc.
72 hours a natural, o		Completed by	3 ₩ Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rking	16b. Kind of Busi	White iness/Industry
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yida nould to Ment marked		2	Lloyd A. Mowen 19a. Informant's Name/Relationship (7)	Time Print	10h Maili	ng Address (Street a			th Kinsey	
E, Mal 1 and 2 st Health and Iem 27 Is n		ľ		Son	118 J	Jason's Ri	idge Sm		, Marylar	nd 21783 ity or Town, State
mit. Pages partment of portant: If it			1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	•	matory or other place 1 Cemeter	1	23, 200)5 Hager	stown, Marylar
Dermit. Departi	- Suce		21. Signature of Funeral Service Licen	X tiny	1	2. Name and Address 331 Easte	Do rn Blyd.	N. Hage	erstown.	
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death death e atter		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti	
v 8 5 2	8.	2	Part II. Other significant conditions o	ontributing to death but not resu	ulting in the u	inderlying cause giv	en in Part I.			oute to the cause of death? B Probably 4 Unknown
Hec elaw has b	page 2 such	Completed						24a. Was autoj perfo 1 🗆 Yes	psy pri prmed? de	ere autopsy findings available for to completion of cause of eath?
OT VITAI F Physician: Th this certificate		Re	25. Was case referred to medical examiner?	Hospital:		Oth	or.	ath (Check only o		
Phys	5	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 27 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur	4 Nursing r		dence 6 □Other how injury occurred ATTON P NOCED	OF SUPEKAL
DIVISION spital or Attending ours after death. naral Director: After	an ka u pa	Certification;	Accident investigation Suicide 6 Could not be determined	6 Geo Class of Injury At he	ome, farm, st	reet, factory, office		City or To	Street and Number	r or Rural Route Number,
543	pietery III	edical	29a. Certifier (Check only one) 1 Certifying Ph	nysicien: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	date and place, ar	nd due to the cause(s)
To the within 2	E CO	Ž	29b. Signature and title of certifier Duril Min	Lynn Sikon	Ron	29c. Licens D 5	e number			(Month, Day, Year) $0 - 1905$
H-10			30. Name and address of person who	completed cause of death (Item				MEYLETHI.	UN, MO	
	Stat	e	31. Date filed (Month, Day Year)	32. Registrar's Signa	<u> </u>	1 .	1 000	-0,-3 10	- / / /	
Red	aistra	ar	AUG 22	2005	A	1				

				partment of Health and N ertificate of Death		ne No. 2005	28510
	D		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Donald Wesley HARBAUGH		August	17 2005	2:15 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death	
			Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washington 9. Birtho	1 lace (State or Foreign
	Funeral Director		218-24-1999 1∏M 2□F 74 Yrs.	Months Days Hours Min.	(Month, Day, Ye March 26	ear) Coun	vland
	ס		Usual Residence of Decedent				
	shoy start	ò					0d. Inside City Limits 1x□ Yes 2 □ No
	the M	Director	Maryland Washington Ha	gerstown 10f. Zio Code	10a.	Citizen of What Cour	
	Sa or	٥	417 McDowell Avenue	21740		U.S.A.	
	deeth ms 2:	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
9	2 should be illed within 72 hours effer deeth with the Maryland and Menial Hygiene. Is marked other than "naturel", or Items 23s or 28e-f show sumatic event, the Medical Examirar must be notified at	/ Fui	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	1 ☐ Yes 21 No Specify:	rican, etc.)	Black, White,	etc.
21215-0036	urel',	d by	3 Wildowed 4 Divorced Year or Dates: 1953-54		100	Whi	
15	n 72 "nat	Completed	(Specify only highest grade completed) (Gillife	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	ing	b. Kind of Business/Ind	dustry
212	d with	шо	Elementary/Secondary (0-12) College (1-4or 5+)	HVAC Tech.	Ai	r_condition	oning
פר	ould be filled v Mental Hygie tarked other t tatic event, to	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid		
<u>Jar</u>	should b and Ments marked	To	Charles J. Harbaugh	Agnes S.	Bryan		
Jar	s 1 and 2 should f Heelth and Men Item 27 is marke other treumatic			ailing Address (Street and Number or Rui			-
e,	1 and 1 and 1 am 27 ther t		0			Md. 2174(c. Location - City or To	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Heelth s Importent: If Item 27 ti any injury or other tre		1 M Burial 2 Cremation 3 C Removal from State	sposition (Name of trematory or other place) wn Mem. Park 8/20/		gerstown,	
İĦ	artme orteni injury		* 4 □ Donation 5 □ Other (Specify) Gedar Lat 21. Signature of Funeral Service LicenSee #	22. Name and Address of Facility M			nar y rand
Ba	permil Depar Impor any ir		James L. Spicer	415 E. Wilson Blvd			21740
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	mm mert			Oriset and Death
	/Medical Examiner	.	resulting in death) Due to (or as a consequence of):	LILE // //	monha	1	X
П	LXammer	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	MIN HA	morara	le	()ay)
	ted nsit	nlne	nause Friter Inderlying Cause (Disease or injury	,			10
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last c				
8760,	cate be executed physician and the burial-transit	dical	d				
9	ntifica ng ph a as th	Med	IF FEMALE:				
Вох	death certific e attending p ed for use as t	lan/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delive Month	Day Year
<u>o</u> .	0 0 0	yslc	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)			
<u>α</u>	requires that the de een signed by the a hould be detached t	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
Records,	quires n sign ald be				1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Unknown
CO	3 40 0	olete			24a. Was an		psy findings available
Re	Phyeiclen: The lav rthis certificete has ral director, page 2 is	Completed			autopsy performed 1 Yes 2	death?	mpletion of cause of
Vital	sien: srtifice ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)		
of <	Physicien: this certific ral director,	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			e 6 Other (Specifi	y)
nc Onc	Jing P	lon:	27. Manney of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how i	injury occurred	
Division	of or Attending efter death. Director: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm,		28f. Location (Stree	t and Number or Rura	l Route Number,
2	effer Dire	Certification:	4 Homicide determined building, etc. (Specify)	1,4	City or Town, S	itate)	
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de control one) 1 Certifying Physicien: To the best of my knowledge, de control one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	tated. the cause(s)
	ithin ithin outpe	Med	29b. Signature and title of certifier	/ 29c. License number	29d.	Date signed (Month,	Day, Year)
}	- > - 0		NIDITE	1 70050	053	08/19/6	1
			30. Name and address of person who completed cause of death (Item 23a) (Tyr	pe, Print) PPI 1	+ 1120	Tala	11/2/7/6
5H	5+1		It by NUVITER (13.	y UMClour	HAUC	79/00/1	VIX 1/42
	Sta Registi		31. Date filed (Month, Day, Year) AUG 19 2005 32. Begistrar's Signature	perte			

			1 - For State of Maryland / Department Certification	ent of Health and Me ate of Death	ental Hygieno Reg. No	Z11115 ZX511
	Physici /Medic		Decedent's Name (First, Middle, Last) Joseph John Hudock 1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	18 2005 12:10 HM
	Examin	er	Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	Hagerstown der 1 Year If Under 24 Hrs.	8. Date of Birth	washington County 9. Birthplace (State or Foreign County)
	Funeral Director		202-32-4403 1X M 2□F 65 Yrs. Month Usual Residence of Decedent		May 8 19	40 Pennsylvania
	he Marylan 8a-f ehow otified at	Director	10a. State 10b. County 10c. City, Town or Location PA Cumberland Shippen		10- 6	10d. Inside City Limits 1 □ Yes X□ No itizen of What Country?
36	ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f ehow or other treumatic event, the Modical Examinar must be notified at	by Funeral Dir	138 Cottage Rd 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) 2X Married 1 \(\text{1 \text{Never Married}} \) 2 \(\text{Never Married} \) 1 \(\text{1 \text{Never Married}} \) 13. Was De If Yes, s	Zip Code 17257 Incedent of Hispanic Origin? (Specification)	Un	ited States 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hour ene. than "natural ne Mudical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of working	g	Kind of Business/Industry
Maryland 2	2 should be filled within and Mental Hygiene. Is marked other than eumatic event, the M.	To Be Co	17. Father's Name (First, Middle, Last) John Hudock	18. Mother's Name	(First, Middle, Maide) Ubiansky	
	Pages 1 and 2 shent of Health and int: If Item 27 is mity or other treum		Gloria Hudock (wife) 20a. Method of Disposition Cemetery, crematory of Company of Comp	Name of Da or other place)	ensburg Pe	ocation - City or Town, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Licensee 22. Name 1331	e and Address of Facility Doug Eastern Blvd. I	glas A. Fi N. Hagerst	enandoah Pennsylvani iery Funeral Home town Maryland 21742
	Physician /Medical Examiner	er	23a. Part. Enter the disease for complications/that caded the death. Do not enter the methods hock, or hear/ailure. List only one causa on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ELUMA	773777 Sis	Approximate Interval Between Present and Death
68760,	The law requires that the death certificate be executed title has been signed by the attending physician end bage 2 should be detached for use as the buriat-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d	7)7182		DAYS
.O. Box 6	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic death 5 ☐ Other 9 ☐ Unknown	c pregnancy (specify)		23d. Date of delivery Month Day Year
_	w requires that been signed b should be deta	ed by PI	Part II, Other significant conditions contributing to death but not resulting in the underlyin	g cause given in Part I.		use contribute to the cause of death?
al Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
on of Vital	Phys this at dir	tion; To Be	27. Manng⊁of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury		(Check only one) e 5 Residence Bd. Describe how inju	
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	tory, office 28	City or Town, Stat	
	To the Hospitel or within 24 hours after or To the Funerel Dirrompletely filled in I	Medical	29a. Certifier (Check only one) (Check o	29c. License number		s) and manner as stated. In place, and due to the cause(s) ate signed (Month, Day, Year)
	18		30. Name and address of person who completed cause of death (Item 23a) Type, Print)	148ERS PUNN	(m0)	71742
	Sta Registr		31. Date filed (Mořtín, Day, Year) AUG 19 2005 32. peglstrar's Signature		, 1117	

		ı	1 - For State Registrar	State of Mar		artmen			and Me	, ,	iene	005	20512
	Physici		1. Decedent's Name (First, Middle, Last) Elbert (NMN) Hubl	ble						2. Date of Deat Month August	_	2005	3. Time of Death 7:40A M
*	/Medic Examir		4a. Facility Name (If not institution, give s 11912 Robinwood I	street and number)		4b. City,		Location o		nagase	4c. Co	unty of Death	
	Funeral Director		5. Social Security Number 6. Sex 216–16–8162	7. Age (i XM 2 ☐ F	In yrs. last birthday 81 Yrs.) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Aug 14	1923	Cou	place (State or Foreign ntry) ntucky
	Maryland a-f show	tor	10a. State 10b. County Maryland Washing		Oc. City, Town or I Hage	ocation erstown	n						10d. Inside City Limits 1 ☐ Yes ② No
	h with the 23a or 28a	ai Direc	10e. Street and Number 11912 Robinwood I	Orive		10f. Zip		742		11		of What Cou	*
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be routified at once.	d by Funerai Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ZYes 2 No If Yes, Give Year or Dates:	3/6/43 12/9/45	Was Deced If Yes, spec		spanic Origin, Mexican Specify:		cify Yes or No- lican, etc.)		Race - Ameri Black, White, pecify: Wh	
Maryland 21215-0036	ed within 72 h ygiene. ier than "natu t, the Madica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dec (Giv life.	e kind of wor DO NOT us Seale	rk done di se retired) er	uring mosi		g	Air	of Business/In	,
yland	ould be filk Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Homer Hubble							(First, Middle, M endygra:			
, Mar	and 2 sho balth and 27 Is m or traum		19a. Informant's Name/Relationship (Ty) Louise Kathryn I	Hubble (wi	fe) 119	12 Ro	ninw	ood D		Route Number, Hagers	•		nd 21742
altimore,	Pages 1 a ent of He nt: If itam y or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disp cemetery, cri Cedar La			_ 1	8–15			ion - City or To	own, State Maryland
Baltii	permit. F Departme Importar any injur		21. Signature of Funeral Service License	Jin.		22. Name an	d Address	s of Facilit	y Doug	glas A.	Fier	y Fuen	ral Home land 21742
	Physician /Medical	9 1	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Carci	noma Lung		e of dying	, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death unknown
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conduction of the conduction of	onsequence of):								
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	∃Fetal death 3	□Ectopic pre					23d	. Date of delive	ery Day Year
rds, P.	quires that n signed b uld be deta	d by Pt	Part II. Other significant conditions con	tributing to death but r	not resulting in the	underlying ca	ause give	n in Part I.		1 -10 7 - 10	acco use		ne cause of death?
Il Records,		Completed								24a. Was ar autops perform 1 Yes 2	/	4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings available impletion of cause of 2 No
Vita	ysician: The is certificate ha	То Ве	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatie	ent 3□ DO	Othe	r		(Check only one		Other (Specif	
Division of	ding Ph h. After th funeral		27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time		Bc. Injury Work		28	3d. Describe ho			<i>y</i> /
Divis	in Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, s Specify)	treet, factory	, office		28	3f. Location (Str City or Town	eet and N State)	umber or Rura	ll Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	Medical	29a. Certifier (Check only one) 12 Certifying Physical Continuous Physical Physi	sician: To the best of ner: On the basis of ex and manner stated	amination and/or i	th occurred anvestigation,	at the time in my opi	e, date and inion, deat	d place, ar th occurred	nd due to the ca d at the time, da	use(s) and te and pla	d manner as s ice, and due to	tated. the cause(s)
	To the To the Comp	N	29b. Signature and title of certifier	γ		1	License	20	10		d. Date si	igned (Month,	Dey, Year)
			30. Name and address of person who co	mpleted cause of deat		, Print)	101	200	14	ve. Ho	tug	ust 1:	21742
St	1-8+1	10	Muhammad 31. Date filed (Month, Day, Year)	AS AVA-		321 (Dak	HIL	LHI	ve. Ho	igers	town	1,111
	Sta Registi		2 1 1 m . d . m	05 Jeneur	. H. D	pele							

/Medi	an	1. Decedent's Name (First, Middle, L GAYE MULLINS					2. Date of De.	Day	Year	3. Time C Death
		4a. Facility Name (If not institution, g.		 	4h City Town	or Location of De	JULY		005	7:00 A M
Examir	ier	SHADY GROVE A		OSPITAL		VILLE	odu i		TGOM	
uneral		Social Security Number 6.		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bird in. (Month, Da			place (State or Foreign intry)
irector		579-12-9895 Usual Residence of Decedent	1□M 2GF	83 Yrs.	Months Days	Hours	Irs. 8. Date of Bird in. (Month, Da OCT 11	" 1921		VA
ehow ad at		10a. State 10b. County	1	0c. City, Town or Lo	ocation					10d. Inside City Limits
nta rygiene. 5d other than "neturel", or Items 23a or 28e-f ehov event, the Medical Eraminer must be notified at	ctor	MD MONTG	OMERY	GAITHER	SBURG					1 Maryes 2 □ No
or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		intry?
s 23a	rai	201 RUSSELL A			20877		/C#VN-	USA		to a feeting
Them	Fun.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces?/ 1 ☐ Yes 2 ☑ No	BI III U.S. 13.	If Yes, specify Cub	oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	BI	ace - Ameri lack, White	
Exa	ρ	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec	ify: WH	ITE
dicel	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	(Give	dent's Usual Occu kind of work done	during most of v	vorkina	16b. Kind of	Business/Ir	ndustry
e Me	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	, life,	DO NOT use retire	ed)		MTODO	D TOT	ogy
nt, th		17. Father's Name (First, Middle, Las	2	COMP	PROLLER	18 Mother's N	lame (First, Middle,	MICRO		OGY
ic eve	To Be	JOEL MULLINS	,				IE ARRIN		arrie)	
other treumetic event, tre M	-	19a. Informant's Name/Relationship					Rural Route Numbe		n, State, Zi	p Code)
her tr			SON		BOX 22	/, BOYI		20841		
-		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	Removal from State	20b. Place of Dispo cemetery, crer FREDERIO	matory or other pla	ATODY	Date 7 / 2 7 / 0 5	20c. Location	-	
any injury o		* 4 ☐ Donation 5 ☐ Other (Spec			2. Name and Addr		1/2//05	FRE	DERT	CK, MD
any i		11/10/		H	ILTON F	UNERAL	HOME			
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused th	e death. Do not ent	ter the mode of dy	Bb BA	ARNESVII. liac or respiratory ar	LE, Mi	D2	0 8 3 8 Approximate
ician		Immediate Cause (Final		TORY FA						Interval Between Onset and Death
dical		disease or condition resulting in death)	Due to (or as a c		LLOKE		. ^>		-	
ner		Sequentially list conditions.	b. HEMOTHO				More			1 week
	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to lor as a o				_			
the burial-transit	Examiner	that initiated events resulting in death) Last	c. RIB FRA Due to (or as a c		1.1	N .W	5		- 4	2 weeks
Pina.	lical E				1 6	MON				
2	e		d.					1		
	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1☐Live birth 2 [∃Ectopic pregnanc			23d. D	ate of deliv	ery
esn.	20	in the past 12 months? 1 Yes 2 No	4 □ Pregnant at tim		Other (specify)			N	fonth	Day Year
ed for use	- <u>S</u>	1 = 111 = 701						-		
ached	Physi	9 Unknown					an Bill			
oe detached	by Physician/M	9 Unknown Part II. Other significant conditions SENILE DEMEI	contributing to death but r	not resulting in the u	nderlying cause gr	ven in Part I.				the cause of death?
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rector, page 2 should be detached	o Be Completed by	9 Unknown Part II. Other significant conditions SENILE DEME!	contributing to death but r		Ott	26. Place of D	24a. Was autop perfor 1 Yes	res 2 No an 24b sy rmed? 2 No	3 Prol	opsy findings available impletion of cause of
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State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death August **Physician** Beverly Ann Jones 2005 11:15P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner 747 Young Way Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) July 1, 1938 Birthplace (State or Foreign
Country) Funeral Months Days Hours Min 1 ☐ M 2 🔀 F 67 Yrs. 214-38-0934 Pennsýlvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumetic event. The Madical Examinar must be notified at 1 Yes 2 □ No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 747 Young Way 21158 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 P Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) daycare assistant childcare 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be finent of Health and Mental Firth 27 is marked of Charles Smith Winnie Spangler 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winnie Jahn/ mother 1980 Pawlet Dr. Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Importent: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 18/10/2005 Silver Spring, MD 22. Name and Address of Facility HartzlerFuneral Home 21. Sign of Funeral Service Lice garine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on a u gd the feath. Do not enter the mode of dying such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner so the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ Mo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation nours after death.

nerel Director: Al

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel [29a. Certifier descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majner stajed. completely 29d. Date signed (Month, Day, Year) 29b. Signature and til 29c. License number WSZ Name and addre is of person who completed c 3 use of death (Item 23a) (Type, Print) outh Center Street Westminister IM) 2115 Flaviohruta MD State Glave & Spark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. C.

			1 - Stete Registrer	State of Mar	yland / Depa <i>Cel</i>	artment of F rtificate of	lealth and Mi Death	ental Hyg Re	ene 200	5 28515
	Physici		1. Decedent's Name (First, Middle, Las Julia A.	•				2. Date of Death Month August	Day Yea 21,2005	3. Time of Death 3:50 A M
	/Medic Examir		4a. Facility Name (If not institution, give Avalon Mano:	street and number)		4b. City, Town, o	r Location of Death	14947	4c. County of De	eath
	Funeral Director			ex 7. Age (i	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6/30/]	Year) 9. E	Sirthplace (State or Foreign Country) nnsylvanis
	e-f show	ctor	Usual Residence of Decedent		oc. City, Town or Lo					10d. Inside City Limits
	th with the 23e or 28	al Director	10e. Street and Number 405 N. Indust:	rial Drive	9	10f. Zip Code 1706	6	10	Og. Citizen of What USA	Country?
036	be filed within 72 hours after death with the Maryland ta Hyglene. d other then "neturel", or Items 23e or 28e-f show event, the Mcdical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spean, Mexican, Puerto F Specity:	cify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify: W	
Maryland 21215-0036	within 72 ho ene. then "netur he Mcdical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired aborer	during most of workin	g	16b. Kind of Busines	ss/Industry
and 2		To Be Co	17. Father's Name (First, Middle, Last)			uborer	18. Mother's Name	(First, Middle, N		V.
_	s 1 and 2 should be f Health and Mental item 27 is marked other treumatic ev	-	19a. Informant's Name/Relationship (and Number or Rural	Route Number,	City or Town, State	
Baltimore,	Page nent o nnt: #		20a. Method of Disposition 1 □ 8urial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify	Manioval Itolii Otate	20b. Place of Dispo	sition (Name of	Pk 8/24	ate 2	20c. Location - City	or Town, State 17260 burg, Pa.
Ball	permit. Departm Importe eny Inju			olter, in mo	1035 D	. Heath	Funeral	Home M	ount Un	17066 i on , Pa .
and the same of th	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	1.	nemmon		ig, such as cardiac of	Tespiratory arre		Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c						10×
68760,	tificate be executed og physician and as the burial-transit	edical Ex	resulting in death) cast	Due to (or as a c	onsequence of):					
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at times 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
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Division of Vital	Jing Ph J. After th funeral	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Injun Wor	v at 2	e 5 🗆 Resider	a) nce 6 □Other (<i>Sp</i> w injury occurred	pecify)
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	V Will	~	29b. Signature and title of certifier	- T-			2323		8/22/5-	
H.	-2		30. Name and address of person who Farid Murshed	19414 Lite	ersburg		agerstow	n, Md.	21742	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 & 2	005 32. Begistrar's	Signature	nete				

			For State of Registrar	Maryland / De <i>C</i>	epartment of H Certificate of I	lealth and Me Death	ental Hygier Reg. I		28516
	Physicia /Medic	an	Donald Jenkins				2. Date of Death Month (August 13)	Day Year	3. Time of Death
	Examin Funeral Director	er	219-20-2688 ¹ X ^M ^{2□ F}		Hay) If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea pril 30,1	ar) 9. Birt	nington hplace (State or Foreign unity) uryland
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o					10d. Inside City Limits
	the Mar 28a-f s notified	Funeral Director	Md. Washington 10e. Street and Number		Hagerstown	n ————————————————————————————————————	10g.	Citizen of What Co	1X Yes 2 □ No ountry?
	ath with	ral DI	750 Dual Highway			21740		U.S	
36	be filed within 72 hours after death with the Maryland ital Hyglene. So other than "natural", or Items 23a or 28a-f show event, the Medical Exameration in the field of the confined at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed Widowed Widowed Vivorced 12. Was Deceded Armed Force 12. Yes 2 13 Yes 2 14 Yes, Give Year or Date	es?	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 hou ene. than "natura to Medicul E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(G	ecedent's Usual Occup ive kind of work done fe. DO NOT use retired	during most of working	7 16b	Kind of Business	
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ylan	should be nd Mental marked o	To Be	George D. Jenkins				nevieve 1		
Maryland	2 8 8		19a. Informant's Name/Relationship (Type, Print) Richard N. Jenkins (Broth		lailing Address (Street) anna Lilly			,	' '
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 iny or other tra		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from St 1 □ Donation 5 □ Other (Specify)	ate cemetery,	isposition (Name of crematory or other place burg Crema	. Aug.	16,	. Location - City or Smithsbur	
Balti	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licensee Jeffrey Lee Day	morting	22. Name and Address J.L. Davis		1252! ome Smit!	5 Bradbur hsburg,Mo	y Ave. 1. 21783
	Pnysician /Medical Examiner	er	Sequentially list conditions, Due to (or	as a consequence of	enter the mode of dyin	ig, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death Cary
68760,	licate be executed physician and s the burial-transit	edical Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c	r as a consequence of):	ilure	-			6 days
P.O. Box 6	death certii e attending d for use a	Physician/Med	in the past 12 months?	ome of pregnancy h 2 Fetal death nt at time of death m	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of del Month	ivery Day Year
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Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 In	patient 2 ER/Outpa	atient 3 DOA	26. Place of Death	(Check only one) e 5 ☐ Residence	6 □Other (Spe	city)
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Division	tal or Attenders after deatlers al Director: ed in by the	Certification:		f fnjury - At home, farm g, etc. <i>(Specify)</i>	, street, factory, office	21	Bf. Location (Street City or Town, St	and Number or Ru tate)	ural Route Number,
	the Hospital in 24 hours a the Funeral D pletely filled i	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	is of examination and/o	or investigation, in my o	pinion, death occurre	d at the time, date	and place, and due	e to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier Out of grant gr	1	29c. Licens	28365	29d.	Date signed (Mont	
БН	-1+1		30. Name and address of person who completed cause AN2AL SHA	of death (Item 23a) (Ty		trul- t	tagest		D21740.
	Sta Registi		31. Date filed (Month, Day, Year) 32. Reg	gistrar's Signature	Specker				

Paul Kiejzik Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 05-05494 State of Maryland / Department of Health and Mental Hygiene 05-05494 Reg. No. 2005 28517 RPD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** <u>August 14.</u> 247 Paul Anton Kiejzik /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 610 South Philadelphia Avenue Ocean City Worcester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs. Director 03/27/1936 Poland 249-86-4067 69 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits wode. r then "natural", or Itams 23a or 28s-1 ehov the Medical Examiner must be notified at 1 Xes 2 No Director Delaware <u>Springfield</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 Monterey Court USA 19064 Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**0 Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 12 Owner/Operator <u>Micro film company</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 end 2 should be fill of Health and Mental H fitsm 27 le marked ott r other traumatic even Paul A. Kiejzik Katarina Kurecki ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Monterey Court, Springfield, PA 19064
lace of Disposition (Name of Date 20c. Location - City or Town, State Kerstin Kiejzik Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
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Important: If its
eny injury or ott 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen 08/17/2005 Frankford, DE 21. Signature of Funeral Service Licenses 108 Williams Street 22. Name and Address of Facility Burbage Funeral Home Berlin, Maryland death po not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final complicating the world votic cardianscular disesses **Physician** disease or condition resulting in death) a Prowning /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical cate hes been signed by the ettending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1, □ Yes 2□ No certificate 1 XYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at SCENE 1 X yes 2 □ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Injury fornal water after 1 Natural 5 Pending Subject s after death. Avg 14, 2005 1 Yes 2 No investigation 12:2f 2 Accident the 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) in by 4 Homicide Atlantic ocean Hospital within 24 hours a

To the Funeral completely filled filled oceanuty, 40 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the I 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Jose MI O.C.M.E. August 15, 2005 who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State 31. Date filed (Month, Day, Year) AUG 1 8 2005 Registrar

asha

L Greenberg

M.D.

		1 - State Unpend Item 2	State of Maryl 3a&27 per m	and/Dep e G847-6	artment of F	lealth and Death	Mental Hyg	giene	00516
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	20ay 2005 ar	2 in o o o o o o
/Medi		STEVEN		M_	ANSBERG				
Exami	ner	4a. Facility Name (If not institution, give s 5901 Forest Road			Che	r Location of Deat		4c. County of De. Prince G	eorge's
Funeral Director		5. Social Security Number 215-62-3174 Usual Residence of Decedent	7. Age (In	yrs. last birthday, 50 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day MARCH 2	1, 1955 WA	rthplace (State or Foreign SHINGTON, DC
Maryland f show	lor	10a. State 10b. County MD PRINCE GE		. City, Town or L	cation CHEVERL	Y			10d. Inside City Limits 1 Yes 2 □ No
r 28a	Director	10e. Street and Number	ORGED		10f. Zip Code			10g. Citizen of What C	Country?
h with	a D	5901 FOREST ROAD				20785		U.S	.A.
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. mportant: If item 27 ie marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, it a Medical Examinar must be notified at	by Funeral I	11. Marital Status 1 ★ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh Specify:	
hin 72 hou s. sn "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind of Busines.	
	Com		5+	DATA	BASE ADMI	NISTRATO	R	UNIO	N
ould be filed Mental Hygi arked other atic event, I	To Be (17. Father's Name (First, Middle, Last) GERALD MANSBERG					ne (First, Middle, FEINGOL)	Maiden Sumame) D	
ss 1 and 2 should be of Health and Mentifem 27 ie marked other treumatice		19a. Informant's Name/Relationship (Ty, KERRI L. MANSBERG			ng Address (Street USHMAN RO			r, City or Town, State, 06278	Zip Code)
Pages 1 and of Her and		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Ponation 5 ☐ Other (Specify)			osition (Name of matory or other place EMORIAL G		Date / 2005	20c. Location - City o	
permit. Page Depertment of Important: If eny Injury or		21. S gnature of Europeal Service Livense		E		eľ füner	AL DIREC	TION, INC.	20852
Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line. Atheroscl Due to (or as a cor	erotic C				rest,	Approximate Interval Between Onset and Death
death certificate be executed to the settled to the ettending physicien and tor use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor						
death certifi e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pro 1 □ Live birth 2 □ I 4 □ Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of de Month	elivery Day Year
uires that n signed b ld be deta	þ	Part II. Other significant conditions con	stributing to death but no	t resulting in the t	underlying cause giv	en in Part I.		bacco use contribute es 2 □ No 3 □ F	to the cause of death?
: The law requires that the cate has been signed by the page 2 should be detached	Completed			-			24a. Was a autops perfor 1 X Yes	an 24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \square
Physicien: rthis certific ral director,	Be	25. Was case referred to medical examiner?	lospital:		oth Oth		ath (Check only or	-	A b
g = 0	ıtlon; To	1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury	of 28c. Injun Wor	4 🗆 Nursing r		ence 6 Other (Sp. ow injury occurred	_{ecify)} At scene
a Figure	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Bural Route Number,
To the Hospital within 24 hours a To the Funeral I completely fitled	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Cardinal Cardina Cardinal Cardinal Cardina Cardina Cardina Cardina Cardina Cardina	sician: To the best of my ner: On the basis of examination and manner stated.	knowledge, dea mination and/or in	th occurred at the tin	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
To the within 2 To the complei	Ž	29b. Signature and title of certifier Rabinula	2 AC	<u></u>	29c. Licens OC	e number ME	2	29d. Date signed (Mor August 21,	ith, Day, Year) 2005
		ZABIUCHH	impleted cause of death		111 Pe	nn Stree	t Balti	more, Mary	1and 21201
St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 6 200	3 Abgistrar's S	Signature	vila				

State of Maryland / Department of Health and Mental Hygiene 2005 28519 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Gerald Leonard Moser 19, 2005 7:35 AM August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12031 Forest Hill Road Clear Spring Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1.2X-M 2.☐ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Min Yrs. 212-24-3579 75 Jan. 23. Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County нет z/ is marked other than "natural", or tlems 23a or 28e-f show other traumatic event, I'm Medical Exartinat has be notified at 1 ☐ Yes 2 No Director MD Washington Clear Spring 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 21722 USA 12031 Forest Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Industrial Equipment 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Mae Gross Alvery H. Moser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 245 Alexis Drive, Ranson, WV 25438 David G. Moser / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 08/22/2005 Hagerstown, MD ō Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Europral Service Licensee 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final were 18chemic Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury onsequence of) Examiner The law requires that the death certificate be executed g physician and as the burial-trans that initiated events resulting in death) Last consequence of) Box 68760. Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the al 1 ☐ Yes 2 ☐ No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate 1 ☐ Yes 2 PN0 ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 □Other (Specify) ဥ 24-No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ₽ 1 Tes inis within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Beath Certification: or Attending Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D004113 UL-D. use of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 3H-4 ■gistrar's Signature State Registrar

	1-	State Registrar		Ce	ertificate of	Boatt	2. Date of Deat	ng. No.	3. Time of De
		Decedent's Name (First, Middle, La.					Month	Day	Yeer
ian ical			namux				AUGUST	4c. County	
ner		Facility Name (If not institution, giv				or Location of Death		Balti	
		ohns Hopkins				r If Under 24 Hrs.	8 Date of Birth		
		Social Security Number 6. S	Sex 7. Age 1 □ M 2 🖾 F	(In yrs. last birthda) Yrs.	Months Day		8. Date of Birth (Month, Day, 1-20-	Year) 1958	Birthplace (State or F Country) Oregon
r	1	19-72-2761		47_ Yrs.			1 20	1750	Oregon
	1	ual Residence of Decedent a. State 10b. County		10c. City, Town or	Location				10d. Inside City
5		MD St. Mar	v's	Cleme	nts				1 ☐ Yes 2
ecto	10	e. Street and Number	7 5	01.01.10	10f. Zip Code		1	0g. Citizen of V	Vhat Country?
늄	100	23057 Grampto	n Road			20624		United	States
Funeral Director	-		12. Was Decedent E	verin U.S. 13	3. Was Decedent of	Hispanic Origin? (Sp	pecify Yes or No-		e - American Indian,
L L	11.	. Marital Status	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto	Rican, etc.)		ck, White, etc.
by F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 N	o Specify:		Specify	. White
D D	_	15. Decedent's E		16a. Dec	cedent's Usual Occ	upation		18b. Kind of Bu	usiness/Industry
Completed		(Specify only highest gr	rade completed)	(Gi	ve kind of work dor DO NOT use reti	ne during most of work red)	king		
盲		Elementary/Secondary (0-12)	College (1-4or 5+	-)		ian Techni		Animal	Hospital
		. Father's Name (First, Middle, Las					ne (First, Middle,	Maiden Suman	18)
Be		Richard Stearns				Bever1	y Ann Ka	lmbach	
2		Pa. Informant's Name/Relationship	(Tuna Print)	19b Ma	uling Address (Stre	et and Number or Ru	rai Route Numbe	r, City or Town,	State, Zip Code)
				230	57 Grampt	on Road,	Clements	, Maryl	and 20624
		ernard Nauman/ H	usband		sposition (Name of				City or Town, State
	20	 ia. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State	cemetery, c	rematory or other p	place)			Maryland
		* 4 Donation 5 Dother (Special		Queen o		i			
500	2	1. Signature of Funeral Septice bid	900						1 Home, P.A
ă		CUUI 11/20	1 Mou	1052	22955 Hol	1ywood Ro	ad, Leon	ardtown	, MD 20650
	2	3a. Part1. Enter the disease, or co shock, or heart failure. List of h	inplications that caused by one cause on each lin	the death. Do not e.	enter the mode of o	lying, such as cardiac	or respiratory ar	rest,	Approximate Interval Betwee Onset and De
n i	l Ir	mmediate Cause (Finaf isease or condition	SEPS						011001 0110 00
		esulting in death)	-	consequence of):					
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	S	equentially fist conditions,	Due to (or as a	consequence of):					
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miner	Č	equentially fist conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events	C.						
Examiner	th re	ause. Enter Underlying ause (Disease or injury lat initiated events esulting in death) Last	c. Due to (or as a	a consequence of):					
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edical	ייי ייי	esulting in death) Last FEMALE: 3b. Was decedent pregnant	d	of pregnancy 2 Fetal death				Мо	onth Day Ye
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n		1	State of Maryland State of Maryland State Unpend Item 23a,27,28a-f pe	d/Depa r me	rtment of He	ealth and M 05 tas eath	lental Hyg	iene 2005	28521
	D		Decedent's Name (First, Middle, Last)				2. Date of Deat Month August	19 2005	3. Time of Death
	Physicia /Medic	ai .	Judith Marlene Owens		4b. City Town and		August	4c. County of Deat	
7	Examin	er	4a. Facility Name (If not institution, give street and number) 10870 Crain Highway, Room 11		4b. City, Town, or Faulkner	-		Charles	
8	Funeral Director	- 1	5. Social Security Number 6. Sex 1 M 2 1 F 7. Age (In yrs. II		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 1	9. Birt 8, 1959 Wa	hplace (State or Foreign huntry) Shington DC
0	pu ,		Usual Residence of Decedent	, Town or Lo	cation				10d. Inside City Limits
	f ehow	_]	01 7	Wald					1 ☐ Yes 2X No
	death with the Maryla me 23e or 28e-f ehou	Director	Maryland Charles 10e. Street and Number	Wala	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	h with	ai Di	19 Graystone Circle		2060	2		USA	
336	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or iteme 23s or 28s-f show event, the Medical Examinar must be collified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His I Yes, specify Cubar 1 □ Yes 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
2-0	"natura	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ition Juring most of work	ing	16b. Kind of Business	/Industry
Maryland 21215-0036	iene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired) ram Analy			Law Enfor	cement
2	be filed v ital Hygie id other ti		17. Father's Name (First, Middle, Last)	rrug		18. Mother's Name	e (First, Middle,		oc.iio.io
an		To Be	John Francis Owens			Patsy	/ Scott		
ary	d 2 should be f th and Mental F 7 ie marked ol traumatic eve		19a. Informant's Name/Relationship (Type, Print)	1	•			r, City or Town, State, .	Zip Code)
	ss 1 and 2 s of Heelth ar I Item 27 ie r other trau		Michael Steckman - Husband	-	The same of the sa			MD 20602	T Chate
altimore,	ges 1 t of H if iter or oth		1 Rurial 2 Cremation 3 Removal from State	emetery, crei	nsition (Name of matory or other place			aldorf, MD	
ij	t. Partmen		4 Donation 5 Other (Specify) HU 21. Signatury of Funeral Service Licensee M01391		ematory 2. Name and Addres			Box 156	
Ba	permit. Pages 1 Depertment of H Importent: If Ite eny injury or ot once.		Jak Hed		untt Fune	•		rf, MD 206	04
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not en	er the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) Weniafaxine I		cation				
	/Medical Examiner		Due to (or as a conseq	uence of):					
		Jer	Sequentially list conditions, if any, tracing to infine diata cause. Enter Underlying Cause (Disease or injury	uence of):					
	kecuted and I-transit	Examiner	that initiated events c.						
8760,	ete be executed hysicien and the burial-transit	al Ex	resulting in death) Last Due to (or as a conseq	Jence of):					
687	physics the l	dical	d						
Box (leath certific ettending pl I for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnancy			23d. Date of de	
	The law requires thet the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		Other (specify)			Month	Day Year
P.O.	thet the d ed by the detached		Part II. Other significant conditions contributing to death but not res	ulting in the	anderlying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rds	quires the n signed Jid be dei	d by					1 🗆 Y	es 2⊡No 3⊡P	robably 4 Unknown
Division of Vital Records,	aw requires s been si 2 should I	Completed					24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
<u> </u>	The i	E					// perfor	med? death? 2 □ No Paye	
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?		othe Othe	26. Place of Dear			
ð	Physi this c	2	1 XYes 2 No 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatie	nt 3 LI DOA	4 🗆 Nursing H		ence 6 Q Other (Speciow injury occurred)	*cify) at scene
6	ding th. : After	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 8-19-05	Injury	Worl	k? Yes 2 X No	Subject	ingested d	lrug
Visi	Atter ector by the	Certification:	3 X Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, st	reet, lactory, office	-	281. Location (S City or Tow	ireet and 10870	Nural Route Number,
۵	itei or irs efte rei Dir led in	Cert	Building				Fau1kne	r, MD	
	To the Hospitel or Attending Physician: The law within 24 hours elter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	29a. Certifier (Check only fine) 1□ Certifying Physician: To the best of my kno 2□ Medical Examiner: On the basis of examina and manner stated.	wledge, dea ition and/or i	th occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	and due to the dred at the time, of	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the To the Complex c	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
			1 (Corheuro)		0.0	C.M.E.		August 20,	2005
			30. Name and address of person who completed cause of death the			eet, Balt	imore,	Maryland 2	1201
	St. Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 5 2005 32. Projectrar's Sign:	ature A	perke				

			For State Registrar		State of N	Maryland	d / Depa <i>Cei</i>	artment of H	lealth ai Death	nd Mental Hy	/giene	005	28522
	Physici	an	1. Decedent's Name	(First, Middle, Last)					2. Date of D Month		Year	3. Time of Death
	/Media	ai		M. O'Bri				4. 0's T		August	15,	2005	11:00 P ^M
	Examir	er	4a. Facility Name (If	not institution, give lity at F				4b. City, Town, or Frede		Death	1	ounty of Death	
	Funeral		5. Social Security Nu			Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24		irth	Frederi 9. Birth	place (State or Foreign
	Director		266-66-559	941[]M 2∭ F	87	Yrs.	Months Days	Hours	Min. (Month, Co. June 1	а <i>у, Үваг)</i> 8 , 191	Cou	achusetts
	pu *		Usual Residence of 10a. State	Decedent 10b, County		10c City	, Town or Lo	cation	-				10d. Inside City Limits
,	Maryla f sho	ō	Virginia	Loudon			ettsvi					i	1 Yes 2 No
	1 the 7	Director	10e. Street and Num	ber				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	h with		13033 Lui	theran Ch	urch Roa	d		20180			U.S.A	١.	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel; or Items 23a or 28e-f show eumatic event, it a Maraical Examination ust be mailified at	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Deceder Amed Force 1 [Yes 2 lif Yes, Give Year or Dates	s? No	1	Was Decedent of H I Yes, specify Cuba	ispanic Origi Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)		I. Race - Ameri Black, White, Specify:	
2	72 ho	Completed	(Specif	15. Decedent's Edu fy only highest grad	cation e completed)		(Give	ient's Usual Occup- kind of work done	durina most d	of working	16b. Kind	d of Business/In	dustry
2	vithin ne. hen.	ld m	Elementary/Secon	idary (0-12)	College (1-4c	or 5+)	Homen	DO NOT use retired)			1	
5	filed v Hygie ther t		17. Father's Name (F)		ношен	акег	18. Mother's	s Name (First, Middle		wn home	9
Maryland 21215-0036	Mental Mental arked o	To Be	Willis Su						Mary	Carrol1			
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other treumatic evonce.		John 0 I	me/Relationship (7) B rien – s e			19b. Mailir R. F	ng Address (Street \mathbf{R} . #1 , Bo	and Number x 56A,	or Rural Route Numi Millboro	oer, City or i	own, State, Zip inia 2	24460
altimore,	ges 1 a t of Hea if item or othe		20a. Method of Dispo	ositien Cremation 3 🗆 F	Removal from Sta	1 00	ace of Dispo emetery, cren	sition (Name of natory or other plac	´ I	Date		ation - City or To	
	it. Pa rtmen rtant: njury		* 4 ☐ Donation :	5 Other (Specify)		Fre		Cremato		-18-2005			
Ba	Depa Depa Impo any i		An ko	(A) Anu	1/2 /	Time.				Stauffer Pike Fr	_		ne v1and 21702
G	'nysician	7	23a. Part1. Enter th shock, or heard Immediate Cause (F disease or condition	t failure. List only o Final	ne cause on each	sed the death	. Do not ent	er the mode of dyin	g, such as ca	ardiac or respiratory	arrest,	K, Maly	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		4	as a consequ	-		1				7 1.001(10)
	LAGITIME	<u>.</u>	Sequentially list con	ditions,	Due to (or o	as a consequ	ones of):						
	nsit	nlne	Sequentially list con if any, leading to important cause. Enter order Cause (Disease or in	nediate lying njury	Due to (or a	as a consequ	ence or):						
<u>_</u>	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) La		Due to (or a	as a consequ	ence of):						
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89	ng ph	Medi	IF FEMALE:										
Вох	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as I	Physician/Me	23b. Was decedent	pregnant	3c. If yes, outcon 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnancy			23	d. Date of delive Month	ery Day Year
0	the a	ysic	in the past 12 r 1 Yes 2 9 Unknown	No	4□Pregnant 9□Unknown		ath 5L	Other (specify)					July 150.
٦.	ires that the de signed by the a l be detached f	/ Ph	Part II. Other signific	cant conditions co	ntributing to death	but not resu	lting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
Records,	quires n sign lid be	d by	compa	nx arte	ib xu	sease	2			1 🗆	Yes 2	No 3□Prot	pably 4 Unknown
000	sw require s been sly should b	Completed	dener	Ha	U					24a. Wa	an :	24b. Were auto	psy findings available mpletion of cause of
2	the lav	mo								— auto perf 1 ☐ Yes	psy ormed? 212No	prior to co death? 1 \(\sum \text{Yes}	mpletion of cause of
Vital	ysicien: Th is certificate director, pag	Be C	25. Was case referre	ed to medical					26. Place o	f Death (Check only			24 40
<u>}</u>	Physic this ce al dire	To	examiner?	No.	lospital: 1 ☐ Inpa	_	ER/Outpatien			ing Home 5 ☐ Res	idence 6	ther (Specif	wassist living
Division of	th. TAfter 1 tunera	on:	27. Manner of Death	5 Pending	28a. Date of tr (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury	Work		28d. Describe	how injury o	ccurred	•
Sic	death death tor: /	icat	2 Accident 3 Suicide	investigation 6 Could not be	28a Place of I	Injuny - At hor	ma farm atr	M 1 []	Yes 2□No		Ctroot and I	Viembor or Pier	Il Route Number,
<u>^</u>	l or At after of Direct Lin by	Certification;	4 🗋 Homicide	determined	building,	etc. (Specify))	eet, ractory, onice		City or To	wn, State)	varriber or mare	ii Houle Number,
	I o the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifics completely filled in by the funeral director;		(Check only	Certifying Phy	ner: On the basis	of examinati	vledge, death	occurred at the time	ne, date and pinion, death	place, and due to the occurred at the time.	cause(s) ar	nd manner as s	tated.
	thin 2 the 1 mplet	Medical	one) 29b. Signature and t		and manner	stated.		29c. License				signed (Month,	
ı	Z ¥ Z 8		Loo. Oignature and t		-/	445			3120	\$	S. Date :	166	
	H		30. Name and addre	ss of person who co	ompleted cause of	f death (Item	23а) (Туре,	Drint)					
	Sta	te	Date filed (Month	Heitzig AUG 1820	32. F (qis	strar's Signati	o lace x	C+ F	16961	ick M	2	1703	
	Registr		1	nou 1 0 20	UU JO	DAY ,	er 14	THE STATE OF THE S					

State of Maryland / Department of Health and Mental Hygiene 2005 28523 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sara Willingham Ostrom August 2005 9:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 909 Mastline Drive Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Sept. 1,1929 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Months 75 Director 409-54-4041 Al ab ama Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r then "natural", or items 23e or 28a-f showing the Modified at Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 909 Mastline Drive 21401 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nat any injury or other traumatic event, the Maries once. 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Speech Pathologist County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bert Willingham Maude Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene Ostrom / Husband 909 Mastline Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 8/19/2005 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A 1 3 he mers Priysician MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner certificate be executed use as the burial-transit Cause (Disease or i that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 NM 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe Completed 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Division of Vital 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physicien: director 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier yletely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 16964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1509 Ritchie Hux Athold James naconas 32. Redistrar's Signature AUG 1 6 31. Date filed (Month State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28524 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 Joshua Nathaniel Picarella August 6:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University Of Maryland 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 218-19-9461 22 Mary land Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 8501 Fortune Place 21793 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 X No Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. ont: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Auto body repair Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Picarella, Jr. Maresa Simons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 is / or other tree 8501 Fortune Place, Walkersville, Md. 21793 Ralph Picarella, Jr. / father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If eny injury or once. Peter's Cemetery Aug. 9,2005 Libertytown, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home Marine 11802 Liberty Rd. Libertytown, Md. 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Multiple Injuries /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No 1 ☐ Yes 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) Aug. 4,2005 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 6:00 AM₁ auto accident XX Yes 2X Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number of Rural Royte Number, City or Town, State) Frederick, Md. Rt. 15 north of Basford Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Street determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number PUDS1924 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI 15801 8/4/05 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 South Greene St. Emily Bellavanu Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elsen & Sporte Registrar 2005

			1 - For State Registrar	State of M		d / Depa	artmen	t of H			F	jiene 19. No 20		28525
3	Physici /Medi	cal	1. Decedent's Name (First, Middle, La FRANCIS XAVIER PI	ROCTOR			45 62	T	I and in a	Di-t	2. Date of Dea	12 - C	Year	3. Time of Death
1	Examir	ner	4a. Facility Name (If not institution, git GLADYS SPELLMAN N					CHEVE	Location of	Death		4c. County		ORGES
	Funeral Director		Social Security Number 6.			last birthday) Yrs.		r 1 Year	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day FEBRUARY	Year)		place (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Maryl	tor	MARYLAND CHARL	ES		A PLAT								1 ☐ Yes 2 X No
	with the	Funeral Director	10e. Street and Number				10f. Zip		_			Og. Citizen of		-
	death v	eral	UNKNOWN 11. Marital Status	12. Was Decedent	Ever in U.	S. 13, V	Was Dece	2064 dent of Hi		in? (Spe	ecify Yes or No-	UNITED 14. Rac	e - Americ	
21215-0036	72 hours after death with the Maryland natural', or Itama 23a or 28a-f ahow dical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	Amed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No		f Yes, spec		n, Mexican, Specify:	Puèrto I	cify Yes or No- Rican, etc.)		ck, White,	
15-0	"natu	ietec	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usua kind of wo	rk done d	furing most	of workii	ng	16b. Kind of B	usiness/In	dustry
212	d within piene. r then "	Completed	9TH GRADE	College (1-4or	5+)	HEAVY I				RATO	R	CONST	RUCT	ION
nd	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last	")		·					(First, Middle,	Maiden Suman		
Maryland	D 2 9 G	10	CLARENCE PROCTOR 19a. Informant's Name/Relationship	(Tuna Brint)		106 14-15-	- 8 d d	(2)			SWANN P		-	
Ma	7 12		GENEVA A. WILSON								I Route Number			·
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	□Removal from State	CI	lace of Disposemetery, crem	sition (Nar	ne of other place	9)	D		20c. Location -	City or To	own, State
Balt	permit. Pag Department Important: It any injury o		21. Sign ture of Funeral rvice	Musta for	583	71 34	ORNIO 439 LI	N FUN VINGS	s of Eacility	ME, I				0640
	Physician /Medical Examiner	Examiner	23a. Par1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. CARDIO R Due to (or as b. CEREBRO	ESPIF a consequ LUNG a consequ	RATORY I uence of): DISEA uence of):	FAILUR SE	E	g, such as c	ardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
P.O. Box 68760,	that the death certificate be executed ode by the attending physicien and detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as d	of pregna 2 □ Fetal	ncy death 3	Ectopic pr Other (sp					23d. Dal Mo	e of delive	ry Day Year
	9 9	þ	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the un	derlying c	ause give	n in Part I.			-		e cause of death?
l Records,	The law ite hes b page 2 s	Completed									24a. Was a autops perform	v r	Vere autoperior to confeath?	osy findings available inpletion of cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				1000			Check only on	e)		
on of	Phys this al dii	tion; To	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	iry	ER/Outpatient 28b. Time of Injury		8c. Injury Work	at at	2	ne 5 ☐ Reside 8d. Describe ho			')
Division	tal or Attencts after death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ury - At ho c. (Specify	me, farm, stre	eet, factory	, office		2	8f. Location (St. City or Town		er or Rura	l Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		nysician: To the best miner: On the basis o and manner sta	of my knov f examinat ated.	wiedge, death ion and/or inv				place, a occurre				
)	To To	2	29b. Signature and title of careful in	MD				D4	2 0	9		Date signed > 8 - (The state of the s
0	82		30. Name and address of person who PAUL DEVORE, M.D.					пеле	DIV 1	A DV	TAND O	705		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7	32. Recent	ar's Signat	ure JA			آ والل	WK I	LAND Z	0785		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician AUGUST POWELL LUTHER 16, 2005 8:18 A MEHRL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months Days Hours 1XM 2□ F Oct.4, Yrs Maryland 78 Director 219-12-1811 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Examinar must be notified at 1X Yes 2 No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 2504 Catoctin Court Apt. 1-C 21702 Funeral 12. Was Decedent Everin U.S.
Armed Forces?
1 MYes 2 □ No World
If Yes, Give
Year or Dates: War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Company Tax Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ellen Stull Luther K. Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dr. Douglas A. Powell / Son 566 Boysenberry Lane, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Chapel Cemetery 8/18/2005 Libertytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility pnce 1621 Opossumtown Pike, Frederick, MD 21702 owither the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pat 1. Foter the disease, of complications that cau shock, or heart failure. List only one cause on add Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to dor, as a consequence of): Examiner en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a o Examiner The law requires that the death certificate be executed sician and burial-trans V a resulting in death) Last Due to (o a consequence of) Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.
To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Z npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of entifier 29c. License number den MD 20015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohiuddin Mohammeu, 11.2.

31 Date filed (Month, DAUG) 1 8 2005

32. Region's Signature 801 Tollhouse Ave., Frederick, MD 21701 Registrar

State of Maryland / Department of Health and Mental Hygiene ? 28527 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Linda Gay Parlier /Medical 2005 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis
If Under 1 Year If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) Feb. 9, 1948 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Country) West Virginia **Funeral** Days Months Hours 214-66-0873 1 ☐ M 2 ☐ F 57 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or Items 23e or 28a-f show Examinst must be notified at 1X Yes 2 □ No Completed by Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Melrob Court Unit 102 21403 United States Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. and: If item 27 is marked other than "netural", or Items 23, and yo other traumatic avant, it. Medical Fain and mury or other traumatic avant, it. Medical Fain and multing the state of 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nursing assistant

18. Mother's Name (First, Middle, 11 heal theare Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be O. J. Akers Sylvia Shuck ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Akers/ daughter 5 Melrob Ct. #102 Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit Page Department of Important: If any in ury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 8-17-05 Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 mandan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to for as a consequence of) Examiner a cteremi Sequentially list conditions, Examiner franky leading to immedia cause. Enter Underlying Cause (Disease or injury Due to (or as a consequent Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Doknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical 26. Place of Death Check on one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Year) DA35 2005 30. Name and address of person who completed cause of deam (Item 23a) (Type, P 16C 31. Date filed (Month, Day, Year) State AUG 1 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. C.

		,	1 - For State Registrar		Ce	rtificate of	Death	F	Reg. No.		
	Physici		1. Decedent's Name (First, Middle, La Anne Frances					2. Date of Dea		3. Time of Dea	
	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death	August	4c. County of		Э•Ш.
	LAGIIII	æ	35833 Army Navy I	rive		Mec	hanicsvil	1e	St. N	Mary's	
Ī	Funeral Director		5. Social Security Number 6. S		80 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 1		Birthplace (State or Fo	reign
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Li	mits
	death with the Maryland me 23a or 28e-f ehow findst te radified at	ţ	Maryland St. Ma	rv's		Mechan	icsville			1 ☐ Yes 2	₽No
	n the	Directo	10e. Street and Number			10f. Zip Code	10071110		10g. Citizen of Wh	at Country?	
	th wit	a D	35833 Army Navy I	rive		206.	59		United S	States	
036	d within 72 hours after death with the Marylan jene. Ir than "natural", or iteme 23a or 28e-f ehow Its Macinal Examinat man be mailfied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 1 1 If Yes, Give Year or Dates:	Ever in U.S. 13.	11160	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
9500-61212	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Give	dent's Usual Dccup e kind of work done DO NOT use retired	ation during most of worki	ing	16b. Kind of Busin	ness/Industry	
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Mar	C1 62 22 29		Richard Brian Pa		Son 4571						
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Ē	it. Pages intment of intent: if it intent: if it njury or o	١.	1 Burial 2 Cremation 3 4 Donation 5 Other (Species			nael's Cer		-2005	Ridge, M	larv1and	
Baitimore,	permit. Pages Department of Importent: If I eny injury or o		21. Signature of Funeral Says Simons	man	2	2. Name and Addre	ss of Facility Br:	insfield	l Funeral	Home, P.A. MD 20650-02	
68760,	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b	a consequence of): a consequence of): a consequence of):	nė L	ung	CAN		Interval Between Onset and Deat	h .
C. Box 6	death cer e attendir od for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month		
ras, r.	requires that the een signed by th nould be detache	by	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the u	underlying cause give	en in Part I.			ute to the cause of death	
al Record	The larate has	Completed						24a. Was a autop perfor	med? prid	re autopsy findings avail or to completion of cause oth? I Yes 2 No	able of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Death				
IO UOI	ding In. After fune	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	v 28b. Time o	of 28c. Injun	4 Nursing nor		ence 6 Other	(Specify)	
DIVISION	al or Attends after death	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at the tin	ne, date and place, a pinion, death occurr	and due to the d ed at the time, d	ause(s) and mann late and place, and	er as stated. If due to the cause(s)	
	To the within To the comple	×	29b. Signature and title of certifier	Los	m	29c. Licenso	41728		29d. Date signed (Month, Day, Year) 24/05	
	50		30. Name and address of person who Patrick Cross,	M.D., 2403			Ho11ywoo	d, Mary	land 2063	36	
Sales of	Sta Registr		31. Date filed (Month, Da AUG 2	4 2005 Regis	r's Signature	Levels					

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	-	Decedent's Name (Firs	, Middle, La	ist)								2. Date of D Month	eath Day	,	Yeer	3. Time of Death
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xamine	r '	4a. Facility Name (If not in							y, Town, or		of Death				of Death	
		Atlantic Ge 5. Social Security Number		Hospi		In vrs. la	st birthday)		Berli er 1 Year		24 Hrs.	8. Date of Bi		orce	ster C	ounty e (State or Foreigi
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Examinational benefited at	200		USSEX	COUNT	ry	FR	ANKFO									1 ☐ Yes 2 🔀 No
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To Table	<u> </u>			RAYNE				-	(2)		JTH		SMITI			
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r other traumatic event, the M	-	20a. Method of Dispositio		(HOTHE	iK)	20b. Pla	ace of Dispo	osition (N	ame of	-	-	Date			City or Town	State
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State of Maryland / Department of Health and Mental Hygiene 28530 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Hollis Reel Jean 900 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) April 13, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land 1 □ M 2XXF Yrs. 80 Director 220-18-0051
Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or items 23s or 28s-f show the Medical Exercises must be notified at 1)(Yes 2 □ No Directo Washington Sharpsburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 West Chapline Street 21782 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. þ Specify: XXWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 10 Weaver Ribbon Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Thomas Hebb Nellie Blanche Stull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17137 Snyder's Landing Rd. Sharpsburg, Maryland 21782
Date 20c. Location - City or Town, State Thomas D. Reel - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State njury or permit. Page Department of Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) View Cemetery Aug. 20,2005 Sharpsburg, Maryland 21. Signature of Funeral Service Light OSDOPME AFTHEFEIT Home, P.A. 425 S. Conococheague St.Williamsport, Maryland Mu Part1. Enter the // sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Merabo **Physician** one week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner meele Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a conseque Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the burial Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by t d be detach Part II. Other significant conditions contributing to #9ath, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Manner of Death ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and oue to the cause(s) and martine, as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29q. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person Boonsboro OSA-R 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla			nt of H				Reg. No.	200	5 2853
	Physici /Medic		1. Decedent's Name (First, Middle, La Catherine Leona		ns	,				2. Date of Dea Month August	16°,		
	Examir		4a. Facility Name (If not institution, giv Contiuum Care At	Sykesville		S	y kesv or 1 Year	Location o				County of Dec	1
	Funeral Director		5. Social Security Number 6. S 219-30-6217 Usual Residence of Decedent		rs. last birthday) 3 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day April			rthplace (State or Foreign ountry) aryland
	Maryland a-f show	tor	10a. State 10b. County W Jeffer		City, Town or Lo		own						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	th with the 23a or 28 21 be not	al Dire	10e. Street and Number 678 Thoroughbred	Drive			ip Code 25414				-	zen of What C SA	country?
900	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show ha Madical Examina must be maillied at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □Yes 2 ▼ No If Yes, Give Year or Dates:		Was Dec If Yes, sp 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		14. Race - Am Black, Wh Specify:	
21215-0036	d within 72 he giene. rr than "natu the Medical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12		(dent's Us kind of w DO NOT	ork done d use retired)	ition luring most)	of workin	9	16b. Ki	of Business	
Maryland	should be filed nd Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last, William Archer W						r's Name lith	(First, Middle, Kapp	Maiden	Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the multiled at once.		19a. Informant's Name/Relationship (Catherine L. Mil 20a. Method of Disposition 1 \$\Gamma \text{Burial} 2 \Gamma \text{Cremation} 3 \Gamma \text{4 GDonation} 5 \Gamma Other (Specifical Content of the Content	ler/Daughter Comparison Co		Tho	rough	bred	Driv	e, Char	1es 20c. Lo		V 25414 r Town, State
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Kicer	Ha Botton V-		< 1 I	1	Hoive	OV R	r Co.,I	nna	op WV	25/,38
,	Physician		23a. Part1 Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the de one cause on each line.	eath. Do not ent	ter the mo	de of dying	, such as	cardiac or	respiratory an	rest,	, wv	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed by the attending physician and begge 2 should be detached for use as the burial-transit and burial-transit and burial-transit and burial-transit and burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons d.	equence of):	- Q 1	cdy.	Ham	6				Days
P.O. Box 6	the death certifice y the attending pt ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ➡No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic	pregnancy				2	3d. Date of de Month	Dlivery Day Year
	w requires that the de been signed by the a should be detached f	Ď	Part II. Other significant conditions of	contributing to death but not r	resulting in the u	nderlying	cause give	n in Part I.			bacco u es 2		o the cause of death?
il Records,	: The law requicate has been page 2 should	Completed								24a. Was a autop perfor	sy	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
Vital	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?	Hospital:			Othe Othe		of Death	(Check only or	7e)		
of	ding After fune	ation; To	1 Yes 2/2No 27. Manner of Death 1/2Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	4 JUNUI	28	e 5 Resid			ecify)
Division	를 를 들	Certification;	3 Suicide 6 Could not b 4 Homicide determined		t home, farm, str cify)	eet, facto	ry, office		28	3f. Location (S City or Tow			ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examone)	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death ination and/or in	vestigatio	n, in my op	inion, deat	d place, ar h occurred	d at the time, o	late and	place, and du	e to the cause(s)
	To To Com	2	29b. Signature and title of certifier	le mo			Doc. License		13-		-	signed (Mon	th, Day, Year)
			30. Name and address of person who Willbu Kus			Print) S+ 3	07	wo	stno	ste	MI	211	57
	Sta Registi		31. Date filed (Morth, Day, Year) - AUG 18 2	295 Stones 32. Tigotrar's Sig	fi.	els	,						

State of Maryland / Department of Health and Mental Hygiene

					,	Cer	tificate of	Death		R	eg. No. 2	005	2853
	Physicia		1. Decedent's Neme (First, Middle, L.	est)					2	Dete of Deet Month	th Dev	Year	3. Time of Death
**	Physicia /Medica		ANNA T. RO	OCHE						AUGUST :			11:15PM
1	Examine		4e Fecility Neme (If not institution, gi		_			•		tion of Deeth	4c. County		
			WILLIAMSPORT NU				if Under 1 Yea	WILL]				WASHI	
	Funeral Director			Sex 7. Age	94	Yrs.	Months Days		Min.	Date of Birth (Month, Dey 10/31/	, _{Yeer)} 1910	9. Birthpla Countr PENNS	ace (Stete or Foreign Y) YLVANIA
	pue #	-	10a. Stete 10b. County		10c. City, T	own or Lo	cation		-			100	d. Inside City Limits
	the Mary 28a-f sh offried	Director	MD WASH	HINGTON	V	VILLI	AMSPORT				0g. Citizen of \	What Countr	1 ∑ Yes 2 □ No
	23a or	ra Dr	147 ARTIZAN ST				2179				USA		
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Maryland 21215-0020	Mantal I	To Be	MARTIN P. COMER	v						KELLEY			
	and 2 sh raith end 27 is m er traum		19a. Informant's Neme/Relationship FRANCIS J. ROCHE			306	GREENBF				-		-
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Balti	permit. Pege Depertment (Important: If any Injury or once.		21. Signature of Funeral Service Lice	nsee	1	²² B	Name and Add ROWN FUNEI MART	ress of Facility RAL HOME INSBURG,	, P.O.	BOX 821	., 327 W.	KING S	ST.,
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ita	certifica rector, p	De l	25. Was case referred to medical examiner?					26. Plece	of Death (Check only on	Θ)		
Ž	N 0 0	9	1 ☐ Yes 2,K No	Hospital: 1 ☐ Inpatie		Outpatien	t 3□ DOA O	ther: 42 Nur	sing Home	5 🗆 Reside	ence 6 □Oth	er (Specify)	
o uoi	Attending Pr tr deeth. ector: After th by the funere		27. Manner of Deeth 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Dey	Year) 281	b. Time of Injury	28c. Inji W	uryat ork? ⊒Yes 2 ⊟N		d. Describe ho	w injury occur	red	
Division	i or Atter eftar der I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not I determined	28e. Place of Inju building, etc	iry - At home . (Specify)	, farm, stre	eet, factory, office	•	28	f. Location (St City or Town	reet and Numb n, State)	er or Rural I	Route Number,
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	To the Comple	ž	29b. Signature end title of certifier	, mD				3700		2	9d. Date signe	d (Month, Di	ay, Year)
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Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28533 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8 Dorothy Tenley Snoots 18 2005 12:31 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Home Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 93 Yrs. 1 ☐ M 2 6 F Director 579-01-4172 5-13-1912 Washington, D.C Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or itema 23a or 28a-f ehov other traumatic event, the Machael Examinar must be rediffed at 1 Yes 2 No Director MD St. Mary's Leonardtown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21665 Joe Hazel Road 20650 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 图 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene important: if item 27 is marked other than any injury or other traumatic event, the hand. 12 Secretary <u> Heating & Air</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Andrew Tenley Beulah Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Snoots / Son <u> 21665 Joe Hazel Road, Leonardtown, MD 20650</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 8-23-2005 Brentwood, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Fu ral Service Licensee M01206 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as parojac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Physician/Medical Examiner burial-transit Due to (or as a consequ attending physician for use as the buria Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Prognant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig , page 2 should b 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No this certificate has After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 RNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of per

J. Patrick

31. Date filed (Month, Day, Year)

Three Notch Road, Hollywood, Maryland 20636

ath (Item 23a) (Type, Print)

24035

M.D.

2005

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				State of Marylan	id / Depa		ealth and M	lental Hygie	•	28534
Ī	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) MARY JANE SING 4a. Facility Name (If not institution, give started in the s	treet and number)		4b. City, Town, or		2. Date of Death Month August	Day Year 18 2005 4c. County of Deat	3. Time of Death 7:30 A.M
	Funeral Director		213-00-0317	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Yes SEPT. 18,	9. Birt	hplace (State or Foreign ARYLAND
	Maryland -f show	tor	Usuel Residence of Decedent 10a. State 10b. County MARYLAND WASHIN		y, Town or Lo		ISBORO			10d. Inside City Limits 1X Yes 2 ☐ No
	death with the Maryland ms 23a or 28e-f show must be notified at	al Director	10e. Street and Number 141 S. MAIN STREET			10f. Zip Code 21	.713	10g.	Citizen of What Co	S.A.
036	ours after el', or Ite Exertine	by Funeral	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	spanic Origin? (Spanic Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, HOMEMA	luring most of worki	ing 16t	OWN	Industry HOME
yland	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) RALPH O'NEAL				CLEMMA			
	s 1 and 2 sho f Health and item 27 ie m other treum		19a. Informant's Name/Relationship (Type RICHARD W. SINES,	SON	6037	APPLETOV	N ROAD,	BOONSBORO	, MARYLAN	D 21713
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ott		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 ponation 5 Other (Specity) 21. Signature of Fameral Se, ice_License	emoval from State MID	DLETOW	sition (Name of natory or other place N LUTH C) N Name and Addres	EM. 8/22	/2005 MI	DDLETOWN NATIONAL	, MARYLAND
ea H	Department		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	Paul M. I	Dean 1	BAST FUNE	RAL HOME	BOONSBOR	O, MARYL	
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	sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hypa	lyder		asc			Chance.
68/60,	ē × ē	cal	d.	Due to (or a onseq	ueace or):					and the same about the same and the
O. Box 6	he death certificat the attending phy ched for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ac. If yes, outcome of pregnation 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of deg □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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ō	Phy ral d	tion: To Be	27. Mann of Death 1 atural 5 Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time of Injury	28c. Injury Work	r. 4 ursing Hor	n (Check only one) me 5 ☐ Residence 28d. Describe how in		sify)
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	edical	29a. Certifier (Check only one) 12 Certifying Physical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death tion and/or inv	n occurred at the tim vestigation, in my op	e, date and place, a inion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	\$ 18/00	5	29c. License	6223	29d.	Date signed (Month	n, Day, Year)
4-	4		30. Name and address of person who con Dr. Praveen Bolarui	m 340 Mills	Street	,	own Mary	land 2174	0 739-71	00
	Sta Registr		31. Date filed (Month, Day, Year) AUG 19 200	32. Registrar's Signa	ture G. In	whi				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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-	Physici /Medio		LETHA MARIE		-61			4b (Site Town or I	AUGUST	17 20 4c. County	005	11:42	PM
-	Examin	er	4a Fecility Neme (If not institut JULIA MANOR HE					40. (HAGERS			ASHIN	GTON	
	Funeral		5. Social Security Number	6. Sex		s. lest birthday)	If Under 1		Under 24 Hrs.		1		lace (State or Fo	oreign
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	r 28s	Director	10e. Street and Number	######################################			10f. Zip C		ПОППОТ		0g. Citizen of V	Vhat Coun	itry?	
	th with	a D	333 MILL STREE	\mathbf{T}				21	740		U	S.A.		
	r dea	Funerai	11. Marital Status	12. Was Dece Armed Fo	dent Ever in	U,S. 13.	Was Deceder	nt of Hispa	nic Origin? (Sp Mexican, Puerto	pecify Yes or No-	14. Rac	e - Americ		
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			30. Neme and eddress of perso	n who impleted cause	of deeth (Ite	m 23e) (Type,	Ţ	_			1		-	-
H-	4		Dr. Praveen	Bolarum 3		1 Stree	et, Hag	gerst	own, Ma	aryland	21740	301-7	39-7100)
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				State of Marylai	•	tificate of			eg. No. 🤌	005	2050
			1. Decedent's Name (First, Middle, Last,)				2. Date of Dea Month	th C	000	3. Time (1) (3)
AL.	Physici /Medio		Mildred Louise	Snyder				August		;	10:50 PM
	Examir		4a Facility Name (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County		10.30 111
	Funeral Director		Williamsport Nurs: 5. Social Security Number 6. Security Number 15		: last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day	Year)	9. Birthpla Country	County ace (Stete or Foreign y)
		ł	216-22-8020 Usual Residence of Decedent	76				Jan. 30	1929	Maryl	and
	yend #	Ì	10a. State 10b. County	10c. C	ity, Town or Lo	cation				100	d. Inside City Limits
	Man	ខ្	Maryland Washingto	on County Ha	gerstov	m					1 StYes 2 □ No
	the 28 m	9	10e. Street and Number	-		10f. Zip Code		1	0g. Citizen of V	What Countr	y?
	A S	₫	911 Guilford Aver	nue Apt-2		2174	0		U.S.A.		
	eath ms 2	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V			Specify Yes or No-		e - Americar	n Indian,
21215-0020	s 1 end 2 should be filed within 72 hours etter death with the Marylend thealth end Mentel Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cu	Hispanic Origin? (suban, Mexican, Puer o Specify:	to Rican, etc.)		ck, White, et	ic.
Ō	2 ho	Completed by	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occ	upation		16b. Kind of Bu		
218	n n	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life. D	kind of work don OO NOT use retii	ne during most of wo red)	orking			
21	liene The	E	7th	College (1º401 54)	Barma	id			Club		
	should be filed withir nd Mentel Hygiene. marked other than umatic event, the Mi	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, I	Maiden Surnam	10)	
<u>a</u>	ld be entel ked o	10 B	Harry B. Coal						-		
Maryland	should of Men marke imatic	-	Harry B. Seal 19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	a Address (Stre	et and Number or R	.e C. Jude Tural Route Number	City or Town.	State, Zip C	Code)
Σ	d 2 sho th end 7 is me traum	-									•
Ġ,	1 en Heal em 2	ŀ	Katherine L. Hawba	Ker/ Daughte	Place of Dispos	ope Ave sition (Name of	nue Apt-1	Hagers	OWN M	arylar	nd 21740
ŏ	Pages lent of int: If its iry or o		1 ← Burial 2 □ Cremation 3 □ P		cemetery, crem	natory or other p	lace)			0.1, 0. 1011	., 0.0.0
Ë	Emeritiment Inch.		4 ☐ Donation 5 ☐ Other (Specify)	Ce	dar Law	n Mem.	Park Aug	19,2005	Hage:	rstowr	n, Maryland
Baltimore,	permit. Pages 1 end 2. Department of Health elimportant: If item 27 is any injury or other trau		21. Signature of Funeral Service License	-7	22.	Name and Add		ouglas A.			
щ	205 8 8		My much	Lunia	133	1 Easte	rn Blvd.				
		/	23a. Part 1. Enter the disease, or compli	cations that caused the dea						A	Approximate
	Physician	(shock, or heart failure. List only or	le cause on each ime.							nterval Between Onset and Death
	/Medical		Immediate Cause (Final	Preumon	ν', Σ					E .	Tda.e
183	Examiner		disease or condition resulting in death)								1 004 7
		ē		Due to (or as a consequ	Jence or):				!	
	uted ansit	edical Examiner	_ t)							
	and and el-tre	Xa	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence or):				!	
68760,	The law requires that the death certificete be executed ate has been signed by the ettending physician and page 2 should be deteched for use es the bunel-trensit	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	;							
387	phys the	둜	resulting in death) Last	Due to (or as a consequ	ience of):				1	
	ding ding	_		1						1	
Box	ath c then or us	lan									
	e de the e	Sic	Part II. Other significant conditions con	tributing to death but not re-	sulting in the un	derlying cause g	given in Part I.	23b. Did to	bacco use cor	ntribute to th	he cause of death?
P.0	at th	£	Endelson Chomas	Obetructive	Pulus	MARCH 1	HSKALE	1 X Y	98 2 No	3 Probal	bly 4 □ Unknown
	ires that signed I d be det	Completed by Physician/N	Chosing Chiome	Obstructive Heart Fa	- " cd MA	00000	N XE'SC				
Records,	v require been si should I	8	Congreling	Institute To	1111100	·		24a. Was a			e autopsy findings able prior to
ပ္ထ	s be	ple	Congestive	TEON (C	SC NOON 6	-				of de	pletion of cause eath?
	he ha	E	•					1 □ Y€	s 2 KNo	10	Yes 2□ No
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of Vital	Physician: r this certitic and director,	Be C	eyaminer?	lospital: 1 Inpatient 2] ER/Outpatient	20 DOA 0	Whor:				
of	Phys ral di	5	27. Manner of Death	28a. Date of Injury	28b. Time of	3LI DOA	+ per-valuesing i	Home 5 ☐ Reside			
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<u>≥</u>	or At efter of Direction by	튑	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		et, factory, office	Ð	28f. Location (St City or Town	, State)	er or murair	toute Number,
	rain Belled	ပ္									
	Hospital 24 hours Funeral etely filled	edical Certification:	(Check only 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occur	e, and due to the ca urred at the time, da	ause(s) and ma	nner as state	ed. ne cause(s)
	To the Nospital or Attending Physicien: The law within 24 hours efter death. To the Funeral Director: Atter this certificate has completely filled in by the tuneral director, page 2	Med	one)	and manner stated.							
_	To the within To the comple	2	29b. Signature and title of certifier	4			nse number	2	9d. Date signed	i (Month, Da	ly, Yeer)
			1 SECTIONA	2		13	3700	1	Moust	- 17	7.005
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, P	rint)			t		,
54	1-7		TED E. HOUTE	154 N.	SITSA	AN S	t. Wil	LIAMSE	ORT,	MD	
82	Sta Registr	te ar	31. Date filed (Month Pay Great) 8 2	32. Registrar's Sign		1.1.		•			

DHMH 16 Rev 6/95

				Please	State of Ma	aryland / D	Depart		lealth a		lental Hy		egible. 2005	28531
	°		, .	Decedent's Name (First, Middle, Last)						2. Date of De		Year	3. Time of Death
		iciar dica nine	l, -	Hazel Elizabeth 4a. Facility Name (If not institution, give			4	b. City, Town, o	or Location o	f Death	August	15.	2005 ounty of Death	6:50 pm M
				Reeders Memorial				Boonsbor		24 110		W.	ashingt	
	Funer Direct			5. Social Security Number 6. Se 215-82-3695 Usual Residence of Decedent	M 2√2 F	83		Months Days	Hours	Min.	8. Date of Bin (Month, Da April			place (State or Foreign ntry) yland
	ryland how			10a. State 10b. County		10c. City, Town	n or Locat	ion						10d. Inside City Limits
	he Ma 28e-f	Director	2	Maryland Washing	ton	Boons						10- 04-		1 ☐ Yes 2 ☐ No
_	a or 3	È		141 S. Main Stree	+-			10f. Zip Code 21713)				on of What Cou	ntry ?
0)	r death	Fire	ם ב	11. Marital Status	12. Was Decedent E Amed Forces?	Ever in U.S.	13. Wa	s Decedent of Hes, specify Cub		gin? (Spe	ecify Yes or No Rican, etc.)		Black, White	
102	ilied within 72 hours after death with the Maryland Hygiene. Hygiene. Inthe Than "natural", or Items 23a or 28e-f show mit, I're Medical Eventuer to Annual to Intiliad at mit, I're Medical Eventuer to Annual to Annual I	ŭ Ž	2	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		Yes 2½ No	Specify:				pecify:	nite
215 0036	72 hours "natural",	2040	Completed	15. Decedent's Edu (Specify onfy highest grad	cation e co <i>mpleted)</i>	16a.	Deceden (Give kin	t's Usual Occup d of work done NOT use retire	ation during most	of worki	ng	16b. Kind	of Business/Ir	
- 1-5	ges 1 and 2 should be filed within 72 hc ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If itam 27 is marked othar than "natur or othar treumetic evant, Its Medical	l um	<u>d</u>	Elementary/Secondary (0-12)	College (1-4or 5-	+)			d) -			77		7
Manufond 24	e filed al Hygi othar	000	บ	Unknown 17. Father's Name (First, Middle, Last)	Unknown		HOI	nemaker	18. Mothe	r's Name	(First, Middle,		er own umame)	nome
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	of Health of Health of Health of Itam 27 is	1	ŀ	20a. Method of Disposition				ittercup on (Name of ory or other place			arersto Date		tion - City or T	
MC: N	permit. Pages Department of Important: If its any njury or of			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 3 ☐ Other (Specify)	Removal from State	1		emetery	1	/18/	05	Rings	old, M	aryland
	emit. Separti	once.		21. Signature of Funeral Service Licens	7	- 1		ame and Addre			nich Fu	inera.	l Home	
Van I		<u></u>	+	23a. Part1. Enter the disease, ir comp shock, or heart failure. List only o	ic Hons that caused	the death. Do n	-	E. Will					ı, Md.	Approximate
	Physicia	_		Immediate Cause (Final disease or condition	ne cause on each lin	the death. Do not be a consequence of the consequen	Sai	lure						Interval Between Onset and Death
4	/Medic Examin			resulting in death)	Due to (or as a	a consequence o	of):	~ 616						10013
	1	i i	<u>.</u>	if any, leading to immediate cause. Enter Underlying	Due to (or as a	AHAYO S	cle of):	NO 818						years
	scuted nd transit	Lyaminar	8	Cause (Disease or injury that initiated events	J									
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607	ificate g phys	od o			d									
93 20	requires that the death certificate be executed requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	hveician/Madi	ICIAILIN	in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	2 Fetal death		topic pregnancy	/			23	d. Date of deliv Month	ery Day Year
0	that the deathed by the atte	Ohve	L .	1 Yes 2 No 9 Unknown	9□ Unknown				i- B1		222 Did A			h
9	w requires that been signed by should be detailed.	7	Š	Part II. Other significant conditions co	2 heimer				ren in Part I.		23e. Did to			he cause of death?
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2	vician: The certificate rector, pag	0	ט -	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗆 Yes	2 No
>	Physician: This certific ral director,	L C	2	1 163 2	lospital: 1 🗌 Inpatier			3□ DOA Oth	er: 4XNur		me 5 ☐ Resid		□Other (Specia	(y)
2	ding P n. After t	2	5	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	y Year) 28b. T	ime of njury	28c. Injur Wor M 1	yat k? Yes 2 □ N		28d. Describe h	now injury o	occurred	
obygon of Vital Doogsale	al or Attendin s after death.	Cortification.	el III ca	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	iry - At home, far :. (Specify)	rm, street		.00 2		28f. Location (5 City or Tow	Street and I vn, State)	Number or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	O leading	2	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and	, death od d/or inves	ccurred at the tir tigation, in my o	me, date and pinion, deat	place, a	and due to the o	cause(s) ar	nd manner as s lace, and due to	tated. o the cause(s)
	To th withir To th	N. O.	ME	29b. Signature and title of certifier				29c. Licens	996				signed (Month,	Day, Year)
- ,	11 2		-	30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type, Prir	nt)						
0	4-4	State		Dr. Zafar Malik, 2 31. Date filed (Month, Day, Year)	0311 Lapp	ans Rd. Ir's Signature	Boor	sboro,	MD 21	713	301-	-432-	8470	
		State istrai		AUG 17 2		-	1	<i>V.</i>						
	DHMH 17 Rev	1/200	1		July July			NEW						·
						ORIC	GINAL							

State of Maryland / Department of Health and Mental Hygiene 2 28538 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month DOROTHY EDWARDS TURNER AUG. 15 2005 11:00PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. A U.G. 1194, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) NC 1 M 2 M 251-34-1696 76 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits treumatic event, the Mudical Examiner must be notified at MD MONTGOMERY POOLESVILLE 1 PYes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19509 WESTERLY AVE. 20837 USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 Is marked other then "neturel", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR SENIOR CENTER 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) RALPH EDWARDS SARAH KIRBY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.3 Department of Health at Importent: If item 27 Is any injury or other treu once. IRVIN TURNER / SPOUSE 19509 WESTERLY AVE., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MONOCÁCY CEMETERY 8/20/05 BEALLSVILLE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Dineral Selvic Li ensee HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hour /Medical Examiner stiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner (or as onsequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed iding physician and se as the burial-transit 51 that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performe 2 No 1□ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 31. Date filed (Month, Day, Year) AUG 1 8 2005 gistrar's Signature State Registrar

		1- State of Maryla	-	artment of F rtificate of		F	Reg. No. 200	
o Physic /Medi		1. Decedent's Name (First, Middle, Last) Michael David Tydings Sr				2. Date of Dea	1 ^{9ау} 2005 ^{Үөа}	3. Time of Death 2:25 A M
Exami	ner		. last birthday)	Hagersto		8. Date of Birtl	4c. County of De Washingt	CON
Director		212-84-1484 ¹☒M ²□F 44 Usual Residence of Decedent 10a. State 10b. County 10c. C	Yrs.			Jan. 14	7961 New	10d. Inside City Limits
ith the Ma or 28a-f s	Director	Maryland Washington Ha 10e. Street and Number	gersto	WIN 10f. Zip Code			10g. Citizen of What	1 ☐ Yes 2/XNo Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any rigury or other traumatic avent, I'm Medical Evandre most be notified at once.	by Funeral	18811 Preston Rd 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Carmed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21742 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ₹ No			USA 14. Race - Ar Black, Wi	
d within 72 ho giene. er than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	dent's Usual Occup kind of work done DO NOT use retired cape Arch	d) -	king	16b. Kind of Busines	•
should be file and Mental Hyl marked othe matic avant,	To Be C	17. Father's Name (First, Middle, Last) John Tydings 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	Judith (Church	Maiden Sumame) r, City or Town, State	Zip Code)
Health an tam 27 is		Marie Tydings/Wife 20a. Method of Disposition 20b.	1881	1 Preston osition (Name of matory or other place	Rd Hager			
permit. Pages Department of mportant: If it any injury or once.		1-3-Buildi 5 Dolemation 2 Diversional nom State	st Have	en Cemete 2. Name and Addre	ry Augo	est Have	Hagerstown n Funeral	MD Chapel
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The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	hyslclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregreating the past 12 months? 1 ☐ It yes 2 ☐ No 9 ☐ Unknown	al death 3	□Ectopic pregnancy	/		23d. Date of d Month	elivery Day Year
requires that	by P	Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cause giv	ren in Part I.			to the cause of death? Probably 4 Denknown
n: The law reicate has bee	Completed						sy prior to death? 2 1 1 1 Ye	
To tha Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To Be	25. Was case referred to medical examiner? 1	ER/Outpatier 28b. Time o Injury	of 28c. Injur Wor	er: 4 🗆 Nursing H		ence 6 ☐ Other (Sp ow injury occurred	recify)
ital or Attairs after dearedeareal Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Special Countries)	nome, farm, sti	reet, factory, office		28f. Location (S. City or Town	treet and Number or F n, State)	Rural Route Number,
tha Hospi hin 24 hou tha Funar npletely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my kn	owledge, deat ation and/or in	vestigation, in my o	pinion, death occu	red at the time, d	late and place, and du	ue to the cause(s)
To To	2	29b. Signature and title of certifier Man Wan		29c. Licens	1660	²	Date signed (Mor	9,2005
H-3	No.	30. Name and address of person who completed cause of death (Ite 2 rica War Italy 401 North	Broad	$\overline{}$	Ltimore	Mary	land 2	1231
St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 2 2005 32. Reflistrar's Sign	B. A	pede		7		

State of Maryland / Department of Health and Mental Hygiene 28540 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Boyd Webb 2005 August 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 168 Williams Drive Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Year 213-32-4677 1**3€** M 2□ F 70 Yrs. Director 1935 June 14, Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow other treumatic event, the Medical Examiner must be notified at Annapolis Maryland Anne Arundel 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 168 Williams Drive 21401 U.S.A. or items 23g Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2. 2. 1 No If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo δ Specify: White 3 ☐ Widowed 4 ☐ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Systems Engineer NASA 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event Blanche Jollimore John S. Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darla Webb/wife 168 Williams Drive Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory 8/17/2005 Baltimore, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) vice Licensee Funera S 21. Signatur-22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician ifal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Year Month Day 5 Other (specify) 4⊡Pregnant at time of death 1 ☐ Yes 2 ☐ No detached been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 2 1 ☐ Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) No 1 Tyes 1 Inpatient 2 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of each 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending within 24 hours after death. To the Funerel Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lanine werry, M.C. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestauk 900 31. Date filed (Month State Registra

State of Maryland / Department of Health and Mental Hygiene 2005 28541 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2005 247 20 David Sylvester Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 ☑ M 2 ☐ F 53 Director July 13, Maryland 219-58-8736 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 ie marked other than "naturel", or items 23a or 28a-f show other treumstic event, the Medical Examinar must be routified at 1 ☐ Yes 2 No St. Mary's Great Mills Maryland Direct 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21029 Little Girls Way 20634 USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 🔯 No Yes, Give 1 Never Married 2 ☐ Married more, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 ie marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason 6 Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Josephine Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: if item 27 is any injury or other tre John Young / Brother 1226 Indian Court, Petersburg, Virginia 23805 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition St. Peter Claver Cemetery 1

Burial 2 □ Cremation 3 □ Removal from State August * 4 ☐ Donation 5 ☐ Other (Specify) 24, 2005 St. Inigoes, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. Muchael lura ardine P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused third ith. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD **Physician** 60 wereds disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Decease of high) that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an certificate has autopsy performed 1 🗆 Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 - Homicide within 24 hours a To the Funerel L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D2982 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Marys JAMES DAMACOUT USSAM State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiens 28542 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 FRANCES 30, 9:00 P.M THERESA ANTONUCCI August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3915 Cloverhill Road Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 16, 1926 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 79 Yrs 219-18-3290 Director Maryland Usual Residence of Decedent with the Maryland 10a. State show 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3915 Cloverhill Road 21218 U.S.A. fited within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then " Elementary/Secondary (0-12) College (1-4or 5+) 12 years permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If item 27 is marked other tl
any njury or other treumatic event, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Browne Eunice 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Antonucci (husband) 3915 Cloverhill Road Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State `4 Donation 5 Other (Specify) 9-2-05 Holy Cross Cemetery Brooklyn, Maryland 21. Signature of Funeral Segvice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician CUTE w /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to for as a consequence of To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial transit Due to (or as a consequence of): O. Box 68760. IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No Division of Vital 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 13115 completed cause of death (Item 23a) (Type, Print) 30. Nam 10 9512 HARFORD Rd # 11 CHAE BARTIMORE MO 21234 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar 2005

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	• Physicia /Medic		Samuel Aguah								August	21,	2005 Year	9:40 p M
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Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Foreign Service Lice		LEON	22. N S t a	Name and	d Addres Anat	s of Facili	y Board	655 W.	Ba1	timore	Street
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			30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Pr	rint)	11.	w St	- 6	z.Hi.	~··	MDO	120]
	Sta	ate	31. Date filed (Month, Day, Year)	15 32. Regist	trar's Signature	han	اع.ق	m al	~)		Dallin	ואים	1 11/ 2	1001
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SAMME AGUAH

State of Maryland / Department of Health and Mental Hygiene 2005 28544 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 30th, 7:15 P. M 2005 Shirley Ruth Bownaker /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4730 Atrium Crt. Owings Mills
II Under 1 Year | If Under 24 Hrs. Baltimore Il Under Months 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Sociel Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🕏 F Director 219-22-7199 78 uly 15, 1927 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Iteme 23e or 28a-f ehow ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Compieted by Funeral Director Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 Atrium Ct. 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 23 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes AND Specify: white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Technologist Lutheran Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ Vernon F. Storm Theresa Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman J. Bowmaker- Husband 20b. Place of Disposition (Name of Baltimore Crematory of Condition Park

20b. Place of Disposition (Name of Date Date Date 20c. Location - City or Town, State Sep. 2, 05 Baltimore City 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If ony injury or 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Enter the disease, or complications may caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARKINSON'S disease Immediate Cause (Final disease or condition resulting in death) **Physician** Kago years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or white) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. sician Physician/Medical phys. use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year jo Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a signed t Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed page 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one. Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number TTENDING D16200 PHYSICIAN 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 720-C MAIDER CHOICE LA. BACTO. MID NORBERTO M. MEACHIRAN, M.D. 32. Regirar's Signature 31. Date liled (Month, Day, Year) State 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 200528545 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer **Physician** 12:38P M August 30, 2005 Delight Frederick Bennett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cockeysville Baltimore Broadmead If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 ☐ M 2 🖾 F Yrs. July 5, 1907 California 98 Director 220-68-6990 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County иетт zr is marked other than "natural", or itema 23e or 28e-f show other traumatic event, I're M. Gical Ex. miner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 USA 13801 York Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify þ White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 04 Bacteriologist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental. Important: If item 27 is marked any injury or care. Frederick Grace Jarvis Clarence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor Clark/Daughter 19 Ruxview Court, Ruxton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Comfort Crematory 9/2/05 Alexandria, Virginia 21. Signature of Funeral Service Licenses
Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 w. Padonia Road, Timonium, Maryland 21093 23a. Part1. En er the cisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart silure. List only one hause on each line. Approximate Interval Between Onserand Death Immediate Ca — inal disease or condition resulting in death) **Physician** /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Day in the past 12 menths? 1 ☐ Yes 2 IZ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use copyribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital/Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No to the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Jurising Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 I Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident after death 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200528546 State Regi**skmend Item #5 Per FH G848 10/1896** Figure of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 10:10 PM Walter Broyles August Carson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Linthicum Anne Arundel Chesapeake Hospice House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 31, 19 Birthplace (State or Foreign Country)
 WV 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F **Funeral** Months Yrs. 86 Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show other traumatic avant, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Brooklyn Park Anne Arundel MD 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. itams 23a 21225 104 Camrose Avenue Pages 1 and 2 should be filed within 72 hours atter death nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or itams 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Carpenter 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be India O'Bryan David Broyles ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Theresa A. Saus / daughter 532 Saltwork Court, Annapolis, MD 21401-6530 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 2005 Department of Important: If any injury or once. Glen Haven Mem. Park ' 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Transport Service Licensee Singleton Funeral Home P.A. MO/3/9 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Mesothelioma Immediate Cause (Final Lmos Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Er to Industrying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 XNo 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atter 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Records, Division of Vital

Box 68760.

P.O. I

Baltimore, Maryland 21215-0036

State Registrar loung

29b. Signature and title of certifier

32 Registrar's Signature

300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Hanover St. Baltimore

29d. Date signed (Month, Day, Year)

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A.	•	1 - State Unpend Item Ragistrar	State of Maryland / Dep 23a&27 per me G847	9-6-05 tas ertificate of Death	rentai mygie Reg	2005	28547
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/Medica		4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of Death		4c. County of Death	
di		3624 Raymonn Ave	nue	Baltimore		NIA	
Funeral		5. Social Security Number 6. S		y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	place (State or Foreign
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aryland		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
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re, Maryland s 1 and 2 should be file Health and Mental Hy Item 27 is marked oth other traumatic event		19a. Informant's Name/Relationship		iling Address (Street and Number or Rui	ral Route Number, C		
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O 2°==		20a. Method of Disposition 1 Description 3 D	Removal from State cemetery, cr	rematory or other place)		RUINGTON	And in case of the
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SIOF endin eath. or: Alt	Certification:	2 ☐ Accident investigatio		M 1 Yes 2 No			
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		30. Name and address of person who	completed cause of death (Item 23a) (Typ			ugust, 40,	2007
			WB10, MD	111 Penn Stree	et Balti	nore. Marv	land 21201
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ricgisi		SEP 0 1 200	J. J. M. R. HELD FO	1					

			State of Maryland / Department	artment of Health and I <i>rtificate of Death</i>	Mental Hygie	ene 2005 28549					
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death					
	Physicia /Medic		Emlie Haslup Crane		August	25 2005 III:45 PM					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death Baltimore					
	·		Oak Crest Village 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Parkville If Under 1 Year If Under 24 Hrs.	8. Date of Birth						
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 MF 7. Age (In yrs. last birthday), 84 Yrs.	Months Days Hours Min.	March 3,	year) 1921 9. Birthplace (State or Foreign Country) Maryland					
-			Usual Residence of Decedent			10d, Inside City Limits					
	uylan show	_	10a. State 10b. County 10c. City, Town or L Maryland Baltimore Parkvil			1 ☐ Yes 2 🕅 No					
	Ba-1	ecto	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?					
	with tage or 2	Funeral Director	8800 Walther Blvd.	21234		United States					
	death	era	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - American Indian, Black, White, etc.					
٥	should be filed within 72 hours after death with the Maryland of Mental Hygene. The Marked other than "netural" or items 23a or 28a-f show marked other than "netural" or items 23a or 28a-f show marked other than "netural".		1 Never Married 2 Married 1 ☐ Yes 2 No	1 ☐ Yes 2XX No Specify:	,	Specify: white					
	ural',	d by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	6b. Kind of Business/Industry							
<u> </u>	in 72 n nei	Completed	(Specify only highest grade completed) Specify only highest grade completed (Given life)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking						
212	d with giene	E O	Elementary/Secondary (0-12) College (1-4or 5+)	secretary		engineering firm					
Maryland 21215-0036	d oth	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	aiden Sumame)					
<u> </u>	should be and Mental marked o	P_	John Garrett Crane	Emlie I		City or Town, State, Zip Code)					
Mai	d 2 sho th and 7 Is m treum				herville,						
	1 and 2 Health tem 27 l		20a. Method of Disposition 20b. Place of Disp	osition (Name of ematory or other place)	- Air	0c. Location - City or Town, State					
ᅙ	Pages nent of I ant: If its ury or o		1 MYRurial 21 Cramation 31 Hemoval from State 1	1	1,2005 B	altimore, Maryland					
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic. Once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edefeld Funeral Home, Inc. Mitchell—Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212								
			23a. Part1. Enter the disease, or complications that caused the death. Do not en								
	Pnysician	S 1	Immediate Cause (Final disease or condition	entra		Onset and Death					
	/Medical		resulting in death) a. Due to (or as a consequence of):								
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
	ed sit	niner	cause Enter UnderNing								
	cate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
8760,	le be e ysicial e buri	dicai	d		 						
ဖ	ng phy as th	Medi	IF FEMALE:								
Вох	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year					
0	he de	ysic	in the past 12 myntus: 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown								
Δ.	that the by detail	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did toba	acco use contribute to the cause of death?					
rds	quires nn sigr uld be	ed by	ansteria that mutut	WA WHE	1 □Yes	s 2 No 3 Probably 4 Monknown					
900	ie law requires tha has been signed ge 2 should be de	Completed	gand afrill bullet	24	24a. Was an autopsy	prior to completion of cause of					
Œ.	The ate has page	E O	0		perform 1 ☐ Yes 2	ned? death? No 1 □ Yes 2 □ No					
/ita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	Other	ath (Check only one						
of	Physic this cral dir	P.	1 Yes 2 FR/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Tursing	Home 5 Resider 28d. Describe hor	nce 6 Other (Specify) w injury occurred					
on	ding th. : After fune	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No							
Division of Vital Records,	Attending or death. ector; After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e, Place of Injury - At home, farm, suilding, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,	reet and Number or Rural Route Number, , State)					
Ö	ital or rs afte ral Dir led in	Cert			1						
	To the Hospital or Atlanding Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	curred at the time, da	ate and place, and due to the cause(s)					
)	To the within To the comp	Me	29b. Signature and title of certifier	29c. Libense number	12	3d. Date signed (Month, Day, Year)					
	3		9. Name and address of person who completed causa of death (Item 23a) (Type Burker Land See U	Elle under	Mark	edle me 21234					
		ate	31. Date filed (Month, Day, Year) SEP 0 1 2005 32 Registrar's Signature	barke							
	Regist	rar	SEP 0 1 2005 BROWN B. A.								

OT	T		Ear	State of Marylan	d /*Departme	nt of Health and	Mental Hygi	ene	
		•	1 - Stata Registrar		Certifica	te of Death	Re	9. No. 2005	28550
	Physicia /Medic		1. Decemn's Name (First, Middle, Last	Chane	9		2. Date of Death Month August	29, 2005 ear	3. Time of Death 8:27 A M
	Examin		4a. Facility Name (If not institution, give			y, Town, or Location of Deat		4c. County of Death	
Н			1914 East 29th 3 5. Social Security Number 6. Se		ast birthday) If Und	altimore er 1 Year If Under 24 Hrs		9. Birthp	place (State or Foreign
	Funeral Director	2	12-44-0090 15 Usual Residence of Decedent	M 2□F 58	Yrs. Months	s Days Hours Min.	(Month, Day,	47 Ne	w YORK
	yland how		10a. State 10b. County	10c. City	, Town or Location			1	0d. Inside City Limits
	8a-1 e	ctor	MD	130	Utimo	re			1 res 2 No
	d within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f ehow Ite Madical Examiral rubal te mulified al	Funeral Director	10e. Street and Number	a Ctroot	10f. 2	ip Code 2121©	10	Og. Citizen of What Cour	ntry?
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ Black, White,	
36	s after , or Its	by Fu	1 Never Married 2 Married	1 Nes 2 No If res. Give	1 ☐ Yes		10 (11041), 010.)	Specify: P. I.	ack
Ö	2 hours	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	16a. Decedeni's Us	uat Occupation		16b. Kind of Business/In	dustry
21215-0036	within 72 ene. than "nai	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	HITE DO NOT	1 1 //	rking		
			17. Father's Name (First, Middle, Last)	LYEARS	113	5abled 18 Mother's Na	me (First, Middle, N	Maiden Surname)	
lanc	Mental Harked of	To Be		LWOOD SR.		ANA	1 L. C	haines	ح
Maryland	s 1 and 2 should be filed Health and Mental Hyg Item 27 is marked othe other traumatic event,	L	19a. Informant's Name/Relationship (7		19b. Mailing Addre	ss (Street and Number or R	ural Route Number,	City or Town, State, Zip	Code)
- 10	1 and Health em 27 ther tr	1	NawcyJ· Wood 20a. Method of Disposition	house (Aunt	lace of Disposition (N	2945t	eet, Ko	1/2 M	2/2/8
Baltimore	ë		Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	rrison te	other place)	alalar	Owner A	4:116 N2
altin	표 문문금 .	'n	21. Signature of Funeral Service Licens		29. Marie	and Address of Facility	119	wings /	ערו יכוו יו
ä	Depa Impo eny i		15000		Vici	105 WOLK	Id Ba	HO ND Z	17/2
			23a. Part Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.					Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		clerotic Card	liovascula	ar Disease	
	Examiner			Due to (or as a consequent	uence on:				
7	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
٧	xecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):				
8760,	ate be executed hysicien and the burial-transit			d					
9	tificate og phys as the	an/Medical		0					
Вох	death certificate be executed e attending physicien and od for use as the burial-transit	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	death 3 □Ectopic			23d. Date of delive Month	ery Day Year
0	at the dea by the a stached f	Physicia	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at time of d 9□ Unknown	eath 5 ☐ Other (specify)	,0,0		
о, С	law requires that the es been signed by th 2 should be detache	by Ph	Part II. Dther significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
Records,	v require been sig should b						1 □ Ye	s 2 No 3 Prot	pably 4 Unknown
jeco	a law re hes be e 2 sho	Completed					24a. Was ar autops perform	y prior to co	psy findings available mpletion of cause of
alF	i ician : The la certificate hes rector, page 2		25. Was case referred to medical				1 ☐ Yes 2	No 1 ☐ Yes	212X No
Vital	Physician: r this certific ral director,	To Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	1.0.	ath <i>(Check only one</i> Home 5 ☐ Reside	nce 6√ΩQther(Specil	v) at goone
n of	ding Phy. h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		at scene
sio	Attending in death.	catio	2 Accident investigation 3 Suicide 6 Could not be		M	1 ☐ Yes 2 ☐ No	206 L (Ca		10-1-1
Division	s efter of Direct ad in by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		ory, office	City or Town	reet and Number or Rura , State)	ar Houre Number,
	To the Hospital or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 2	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the ca urred at the time, da	tuse(s) and manner as s ate and place, and due to	tated. the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	^	1 -	9c. License number	29	9d. Date signed (Month,	
			1 Closhe	M)		O.C.M.E.		August 29	, 2005
	6	2	30. Name and address of person who d	completed cause of death (Item		nn Street, Ba	ltimoro	Maryland C	21201
	Sta	ate	31. Date filed (Month Day, Year) 1	32. Registrar's Signa	iture	A A	TCTHOLE,	THE YEAR 2	
	Registr		SEP U 1	William COU	S. BORN				

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20b perFH G847 971 05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2005 28551 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 20:25 PM AUGUST 29 **Physician** 2005 Victoria L. Crawford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 1966 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 39 Yrs. 5 Social Security Number **Funeral** Months 1 ☐ M 2 🛱 F Maryland Director 215 96 8029 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Medical Examinat must be redified at 1 ves 2 No Baltimore Directo Maryland N/A 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S. 21229 22 S. Athol Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after of Hygiene. 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Heelih and Mental Hyglens. Important: If itam 27 is marked other than "ns eny injury or other traumatic avant, the Madia once. Elementary/Secondary (0-12) College (1-4or 5+) Amico Gas Station Cashier 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Betty J. Sulser David F. Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Birdknoll Court Baltimore, Maryland 21227 19a, Informant's Name/Relationship (Type, Print) 15 Birdknoll Court Tariq Mahmood / Husband unk Date 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway baltimore, Maryland 21225 manuacello 23a. Pant. Enter the disease, are implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. MONTHS Immediate Cause (Final NOSOCO MIAL PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): INFARCTION HOURS **Examiner** MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE and It-transit YEARS Due to (or as a consequence of) been signed by the attending physicien a should be detached for use as the burialby Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □ Yes 2 No 4☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, MELITUS 1 Yes 2 No 3 Probably 4 Unknown DIABETES page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 2X No 2 No 1 Yes 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours efter death.
To the Funeral Director: At completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chack only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 717602 AUGUST, 29th, 2005 Uninterenics 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LARYSA KWINTKIEWICZ, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#19b, perFH C847,9/1/05 TT State of Maryland / Department of Health and Mental Hygiene 2005 28552 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 15 PM **Physician** JEANNETTE R. CHRISTMAS AUGUST 30,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 06 HOSPITAL 8. Date of Birth (Month, Day, Year) 4-25-1902 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1□ M 2\ F MARYLAND 103 216-54-0974 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits wode ! 10a. State 10h County r then "netural", or iteme 23a or 28a-1 ehov Tre Missical Examiner must be notified at BALTIMORE 1 XYes 2 No N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 USA 1190 W. NORTHERN PKWY. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo 1 Never Married 2 Married Specify: BLACK If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ 3 ♥Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC -12--0-HOMEMAKER traumatic event, 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental if item 27 is marked ADDIE HARVEY WILLIAM RICHARDSON ပ 19b. Mailing Address 1974 and Number of Bush Route Vember Bill of Four State. Zin 1902 1215 IN LAW) 1190 W. MORTHERN PRWY SALTH 1028, MD 21210 19a. Informant's Name/Relationship (Type, Print) VASHTI W. CHRISTMAS (DAUGHTER IN LAW) other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it eny injury or o 1 🔯 Burial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 9-3-2005 BALTIMORE, MARYLAND 4 Donatio 5 Cher (Specify) HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. MATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Perkalen a consequence of): /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 🗆 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Sinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No 2 ER/Outpatient 3□ DOA Certification; To 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of After Division 1 Natural or Attending 5 Pending investigation death. 1 Tyes 2 No 2 Accident completely filled in by the Director: 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 AUGUST 30,2005 MD who completed cause of death (Item 23a) (Type, Print) M.D. SINAI MOSPITAL OF BALTIMORE, MD-21215 LAWNENCE KOMAL 31. Date filed (Month, Day, Year) 32

DHMH 17 Rev 1/2001

State Registrar

SEANETT

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JHK!

State of Maryland / Department of Health and Mental Hygiene 2005 28553

		•	For State Registrar	Oldio or ivi	arytana / E	Certifica	ite of Deat	h		g. No.	J
	No. oi oi		1. Decedent's Name (First, Middle, La	st)					2. Date of Death Month	Day Yee	
	hysici: Medic/	al	Achillio J.						August 2	2, 2005	6:30 PM M
· ·	Examin	er	4a. Fecility Name (If not institution, giv			4b. Cit	y, Town, or Locatio			4c. County of De	
			7922 Philade			at at a left line	Baltimo		0. D	Baltimo	
	uneral rector		217-12-3137	ex 7. Ag	e (In yrs. last bir 83	Yrs. Month		s Min.	8. Date of Birth (Month, Day, Feb 23,	1922 M.	irthplecs (State or Foreign Country) aryland
and	ž	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
Maryl	f eho	ō	MD Baltimo	ro	R	altimor	Δ.				1 ☐ Yes 2 ☐ No
the	28a	Director	10e. Street and Number	16	Б		Zip Code		10	g. Citizen of What	
with	3a or	0	7922 Philadelph	aia Pond			21237	,		TICA	
death	TEST.	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was De	cedent of Hispanic (pecify Cuban, Mexic		city Yes or No-		nerican Indian,
G Z IZ IO-UUSO filed within 72 hours after death with the Maryland Hygiene.	rei', or iteme 23a or 28a-f ehow Executive court be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		2 No Speci		rican, etc.)	Specify: wh	
5 E	"naturel", edical Exp	Completed by	15. Decedent's E (Specify only highest gra	ducation	16a.	Decedent's U	sual Occupation work done during m	act of wardin	1	6b. Kind of Busines	ss/industry
thin 7		nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT	use retired)	OSE OF WORKIN	9		
filled wi	other then	Col	12	0		parts	departmen			General	Motors
<u> </u>	to po	Be	17. Father's Name (First, Middle, Last				18. Mo			aiden Sumame)	
should be	marked matic ev	ဥ	Abramo DeLuca		1.0		(2)		ncy DeLt		T 0 11
Maryland d 2 should be file th and Mental Hy	Treum Treum		19a. Informant's Name/Relationship (Anna DeLuca/spou			_	iladelphi			City or Town, State	
C 7	t: If item 27 ie marked 7 or other treumatic e		20a. Method of Disposition			Disposition (A				Oc. Location - City	21237 or Town, State
SALTIMOFE, permit. Pages 1 a Department of Hez	ant: If it ury or o		1 ☐ Bunal 2 ☐ Cremation 3 ☐ 1 ☐ Sunation 5 ☐ Other (Special Control of the Con	y) /	cemete	ry, crematory o	r other place)	 			
Dermit.	important: If eny injury or once.		21. Signature of Funeral Service Lice Ronal d S	Wade Dir	ctor	State	-	Board	655 W. 1	Baltimore	Street
	1		23a. Pentl Enter the disease, or com shock or heart failure. List only	plications that caused	the deeth. Do	not enter the m	nore, MD ode of dying, such	as cardiac or	respiratory arre	st,	Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	· CEREB		11 1	ACCINE	NIT			Onset and Death
/M	edical		resulting in death)		e consequence		ACCIDE	101		P-0/	1 0773
Exa	miner		Saguestially list conditions	b. DIABE	TES						10 YEARS
n	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):					3 YEARS
ecute	trans	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	C. HYPER	TENSIO	N					3 YEARS
00°	cian a		resulting in death) Last	Due to (or as	a consequence	of):					
5875U, ificate be ex	physician and s the burial-transit	Medical	•	d							
OX O	ටු ශ		IF FEMALE:	23c. If yes, outcome	of pregnancy					204 Date of a	4-15
Bath	attendin for use	Physician/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic 5 □ Other				23d. Date of o	Day Year
je di la di	by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	turio di dodi.i	0 🖂 0 11101					
T is	deta		Part II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying	cause given in Pa	rt I.	23e. Did tob	acco use contribute	to the cause of death?
on Tales	been signed b should be deta	d by				·			1 □ Ye	s 2 7 No 3 □	Probably 4 Unknown
Hecords, The law requires t	shou	iete							24a. Was an		autopsy findings available
	s certificate has l lirector, page 2 s	Completed							autopsy perform		
	rtifica tor, p	0	25. Was case referred to medical				26. Pla	ace of Death	(Check only one		
T V	direc	To B	examiner? 1 ☐ Yes 2 ☑ Ńo	Hospital:	ent 2 ER/Ou	utpatient 3	DOA Other: 4	Nursing Hom	ne 5 Aesider	nce 6 Other (S)	oecify)
0 g	fter this neral dii		27. Manner of Death 1 ☑Ñatural 5 ☑ Pending	28a. Date of Inju (Month, Da	ry 28b.	Time of	28c. Injury at Work?	2	8d. Describe ho	w injury occurred	
andir O	rector: After by the funer	atic	2 Accident investigation	n		М	1 □ Yes 2	□No			
DIVISION OF VITAL el or Attending Physician: 7 s after death.	I Direct	Certification:	3 Suicide 6 Could not be determined	289. Place of Inf	ury - At home, la c. (Specify)	ırm, street, lact	ory, office	2	81. Location (Str. City or Town,		Rural Route Number,
DIVISION OF VITA To the Hospitel or Attending Physicien: within 24 hours after death.	To the Funeral Director: completely filled in by the	Medicai (29a. Certifier 1 ☑ Certifying P (Check only one) 2 ☐ Medical Exa	nysician: To the best miner: On the basis o and manner st	f examination ar	e, death occurrend/or investigati	ed at the time, date on, in my opinion, d	and place, a death occurre	nd due to the ca d at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To th	To th	Me	29b. Signature and title of certifier		1		29c. License numbe	er.	29	d. Date signed (Mo	nth, Day, Year)
- >			James J	Law	6		D00 62	2032	1	FUGUST Z	6 2005
			30. Name and address of person who	completed cause of o	leath (Item 23a)	(Type, Print)					
			JENNIFER	HAYASHI	MD,	5505 H	OPKINS BA	YV.EW	CIRCLE .	BALTIMOR	E, MD 21224
7	Sta		31. Date liled (Month, Day, Year)	32. Registr	ar's Signature	Courtes					

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			1 - For State Ragistrar	State of M	larylan	id / Depa	artme <i>rtifica</i>	nt of H te of L	ealth a Death	ind M		giene 2 (05	28	554
	Physici /Medic		1. Decedent's Name (First, Middle, L Frederick (erman						2. Date of Dea Month August	Day 30	Year 2005	3. Time of 11:15	Death A^M
	Examir		4a. Facility Name (If not institution, g 2525 Pot Spring 1 5. Social Security Number 6.	Road, Apar	tment	L411 last birthday)	Co.	ckeys	Location of Ville	24 Hrs.	8. Date of Birt]	y of Death Balti		or Foreian
	Funeral Director		579-52-8149 Usual Residence of Decedent	1 ДХ М 2□F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Sept 07	, Year) 914		place (State ontry) W Jers	
:	8a-f ehow	ector	Md. Baltimo	ore		ny, Town or Lo monium								10d. Inside Ci	
	23a or 2	Funeral Director	10e. Street and Number 2525 Pot Spring F	Rd. L411				2109				10g. Citizen of		usa	
920	/z nous aller deall with the maryland natural', or items 23a or 28a-f ebow iteal Ezamanar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces	?	.S. 13.	Was Dec If Yes, sp 1 Yes		spanic Orig n, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ack, White, fy: Whi		
121	then *	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or +4	5+)	1	dent's Us kind of w DO NOT fice	ork done d use retired	ation du <i>ring</i> most)	of work	ing	16b. Kind of E		ndustry	
yland	should be riled nd Mental Hygis i marked other umetic event, ii	To Be C	17. Father's Name (First, Middle, Las Heinreich	Diermann					Soph	nie	e (First, Middle, Ko	ор			
, Mar	Health and the mand t		19a. Informant's Name/Relationship Mrs. Catherine Di		fe		•				a <i>l R</i> oute Numbe _411			,	
imore	5 O		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		0	Place of Dispo cemetery, cre 11top	matory or Serv	ice C	o. ∤9	-1-0		Towson	•	own, State	
Balt	permit. Fag Department Important: 8 any injury o		21. Signature of Funeral Service Lic	ensee		2:	RUSK	Tows York	on Fulling	nera Tows	l Home;	Inc 21204			
	hysician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that cause y one cause on each a Due to (or a:	ine.	ente			_	70	or respiratory and	rest,		Approximate Interval Bets Onset and D	ween
8760, ~	cate be executed hysicien and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as											
P.O. Box 68	ine iaw requires trait ine dearn certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	⊒Ectopic ⊒ Other (s						ate of delive		/ear
rds, P	w requires man been signed b should be deta	b	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	ındərlying	cause give	en in Part I.			bacco use con es 2 🗆 No	tribute to t	1.	eath? Jnknown
		Completed									24a. Was a autop perfor 1 Yes	sv	Were auto prior to co 10 /11? 1 Yes	opsy findings a impletion of ca 2 No	available ause of
E	rnysician: In this certificate ral director, pag	9 Be	25. Was case referred to medical examiner? 1 N Yes 2 No	Hospital: 1 Inpat	iam 0.	IED/Out		OA Othe			me 5 ☐ Resid			ont go	ono
on of	After fune	tion; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D	ury	ER/Outpatier 28b. Time of Injury		28c. Injury Work	4 🗆 1401		me 5 Hesid 28d. Describe h			yal sc	ene
Division	To the nospital or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not 4 Homicide determine		njury - At ho tc. <i>(Specif</i>	ome, farm, st	reet, facto	ry, office			28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route Numi	ber.
:	A Funera	edical C	29a Certifier 1_ Certifying (Check only one) 2 Tymedical Ex	hydician: To the best aminer: On the basis and manner s	of examina	wiedge dast ition and/or in	h scours vestigatio	d at the tim n, in my op	a date and pinion, deat	place h occurr	and due to the ored at the time, or	auea(e) and m late and place,	armar as s and due to	tated. o the cause(s))
. 1	within :	Me	29b. Signature and title of certifier	1 11	,		29	c. License	number		2	29d. Date signe	ed (Month,	Day, Year)	
	1-1		30. Name and address of person wh	o completed cause of	eath (Iten	n 23a) (Type,	Print)	0.0	.м.е.			August	31,	2005	
	511		THEODORE MIK	129		111	. Pen		eet,	Balt	timore,	Maryla	nd 21	201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	ar's Signa	ature /	A STATE OF THE PARTY OF THE PAR	dis.							

State of Maryland / Department of Health and Mental Hygien 2005Certificate of Death

28555

Physicia /Medic Examin

1 _ State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examination at 1000.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 logisti di			110	j. 100.		
an	1. Decedent's Name (First, Middle, Last)	_	1/ -	2. Date of Death Month	Pay Year 3. Time of De	eath	
al	ADA		OOKS	AUG .	29 2006 11:18	A ^M	
er	4a. Facility Name (If not institution, give street and number)	0	4b. City, Town, or Locatio		4c. County of Death		
5	GREATER BALTIMORE MEDICA			HORE er 24 Hrs. 8. Date of Birth	NIA		
	111 AT 1 1111 10M 280F	(In yrs. last birthday)	Months Days Hours	Min. (Month, Day, 1	9. Birthplace (State or F Country)	oreign	
	Usual Residence of Decedent	00		JUNE 1,	MIT VIKGIN	/A	
	10a. State 10b. County	10c. City, Town or Lo	ocation	1	10d. Inside City I	Limits	
tor	MARYLAND BALTIMORE		RANDAL	ISTOWN	1 □ Yes 2	N O	
rec	10e. Street and Number		10f. Zip Code		g. Citizen of What Country?		
	4118 TIVERTON F	ROAD	2	1133	115A		
Jer	11 Marital Status 12. Was Decedent I	ever in U.S. 13.	Was Decedent of Hispanic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - American Indian,		
Fū	1 Never Married 2 Married 1 Yes 2 N	lo			Black, White, etc.		
l by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No Speci	ry:	Specify: BLACK		
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	ost of working	6b. Kind of Business/Industry		
dm	Ejementary/Secondary (0-12) College (1-4or 5	+) life.			Aug Illano		
S	8 TH GRADE	<u> </u>	TO ME MA		OWN HOME		
Be	17. Father's Name (First, Middle, Last)	- h /	18. MO	ther's Name (First, Middle, M.			
은	USIE	144701	<	-DA_	JONES		
	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Nutr) 1	City or Town, State, Zip Code)		
	CARL TAYLOR (BROTHE 20a. Method of Disposition	20b. Place of Dispo	psition (Name of		BINE NJ. 0827 Dc. Location - City or Town, State	0	
	1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cres	matory or other place)				
	* 4 Donation S Other (Specify) 21. Signature of Funeral Service Licen 960	TREBUTO			SALTIMORE MARYL	AND	
	1 ((A ~ () , D)	γ	2. Name and Address of Fig.	LTON AVE . B	R. FUNERAL HOI ALTO, MD. 212	17	
1	23a. Part1. Enter the disease, or complications that caused	the death. Do not ent			t. Approximate		
	shock, or heart failure. List only one cause in each lir Immediate Cause (Final	ne.	DEME	. VII 0	Interval Betwee Onset and Dea		
	disease or condition resulting in death)	a consequence of):	+ COIL	10/114			
	333.5 (5.43	2 0011004201100 0.17.					
Jer	Sequentially list conditions, if any leadin, to immediate ause. Enter Underlying	a consequence of):					
III.	Cause (Disease or injury that initiated events						
EX	resulting in death) Last Due to (or as	a consequence of):					
an/Medical Examiner	d.						
Med	IF FEMALE:						
an/l	23b Was decaded prograph 23c. If yes, outcome	of pregnancy 2 ☐ Fetal death 3 [Ectopic pregnancy		23d. Date of delivery Month Day Yea	ır.	
sic	1 ☐ Yes 2 No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)		World Day 100	"	
Completed by Physic	Part II. Other significant conditions contributing to death b	ut not resulting in the	inderlying cause given in Da	rt1 23e Did toba	cco use contribute to the cause of deal	th?	
l by	Nidocore	MELL			2 No 3 Probably 4 Dunk		
etec		1000	<u> </u>				
Idm				24a. Was an autopsy perform	24b. Were autopsy findings ava prior to completion of caus death?	se of	
ပိ				1 Yes 2	No 1 Yes 2 No		
Be	25. Was case referred to medical examiner? Hospital:			ace of Death (Check only one,			
: To	1 Yes 2 No 1 Inspired 1 Inspired 27. Manger of Death 28a. Date of Inju		f 28c. Injury at	Nursing Home 5 Residen			
tlor	Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	Work? M 1 □ Yes 2				
ifica	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, st	reet, factory, office	28f. Location (Stre	et and Number or Rural Route Number	ς.	
Sert	4 Homicide determined building, etc	c. (Specify)		City or Town,	State)		
Medical Certification;	29a. Certifier Certifying Physicien: To the best	of my knowledge, deat	h occurred at the time, date	and place, and due to the cau	se(s) and manner as stated.		
edic	(Check only one) 2 Medical Exeminer; On the basis of and manner sta	examination and/or in	vestigation, in my opinion, d	leath occurred at the time, dat	e and place, and due to the cause(s)		
Σ	29b. Signature and title of certifier		29c. License numbe	290	1. Date signed (Month, Day, Year)		
	· Waller tomer	9	1)536	150	4-1-05		
	30. Name and address of person who completed cause of d			TIPPAP	11/201-	01	
	31 Date filed (Month Day York)	ar's Signature	220A EAS	1 701146	1 UNON UT	86	
te ar		ar's Signature					
-	SEP 0 1 2005 States	- 1					

Sta

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eleanor Geiser July 2005 1:00AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9010 Briancroft Lane Laurel Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 29, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 211-05-5922 87 1917 Pittsburg. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28e-f show 1 XYes 2 No MD Director Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Briancroft Lane 20708 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Aviation Elementary/Secondary (0-12) College (1-4or 5+) Administration Credit Secretary 2 years 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other traumatic event 900g. 17. Father's Name (First, Middle, Last) Be Benjamin Shulgold Lillian Shulgold

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11811 N. Lincoln Ave. Beltsville, MD 20705
ace of Disposition (Name of Date 20c. Location - City or Town, State Sam Geiser / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Howard Medical School 7/4/05 ` 4 ∑Donation 5 ☐ Other (Specify) Washington, DC 21. Signature of Euneral Service Licensee Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disertail, or compile thous that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art 1 liure. List only one cause of a 151 line. Immediate Cause (Final disease or condition resulting in death) Neoplasm, Parotid 142.0 **Physician** 2months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5\(\text{N Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Certification: To 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D0036716 August 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D. 8317 Cherry Lane Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2005

ORIGINAL

Registrar

filed within 72 hours after

The law requires that the death certificate be executed

attending physician

certificate

To the Hospital or Attending Physician:

24 hours To the Funerei

Division of Vital Records, P.O. Box 68760,

al Hygiene.

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene? 28557 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Gary Gonzalez 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millenium Franklin Square Baltimore 8. Date of Birth (Month, Day, Year)
Apr 17, 1955 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Yrs. Maryland 50 Director 218-70-7428 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Mudical Examinar must be notified at 1√Yes 2 No Director MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1217 W. Fayette Street 21223 Funeral <u>USA</u> 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1√2 Yes 2□ No Specify: unk Specify: black þ 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Walte. Elementary/Secondary (0-12) College (1-4or 5+) unk laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk Benito Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Gonzalez/sister in law 463 Caledonia Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒Other (Specify) in state 21. Signature of Forneral Service Licensee

Ronald S. Wade Divertor

State Anatomy Board 655 W. Baltimore, MD 21201

23a. Part Enter the disease, To implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the control of t State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Interval Between Onset and Death Immediate C hase (Final disease or condition resulting in death) Bleeding Physician /Medical Due to (or as a consequence of): RRHOSIS OFLIVER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Schknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No r: After this certifica e funeral director, p To the Hospital or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Dursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2000 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by filled in by 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 24100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RABHAKARM. D. 300 ARMORY PLACE BAL, MD21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elmer H. Aparte Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Ö

Division of Vital Records, P.

W

Pleas

7. Age (In yrs. last birthday) If Under 1 Year Months Days

Yrs.

D T ... E O. . T . . E

10c. City, Town or Location

100

Please Type or Print in B	lack Indelible Ink. Ensure A	II Copies Ar	e Legible.		
For State of Maryland	d / Department of Health and I Certificate of Death	Mental Hygiei		285	58
Decedent's Name (First, Middle, Last)		2. Date of Death	D	3. Time of De	
SOPHIE GLICK		AUGUST	Day Year ZOC5	12:55	PM

RANDALLSTOWN

Hours Min. 8. Date of Birth AUG. 15,1905

4b. City, Town, or Location of Death

BALTIMORE

9. Birthplace (State or Foreign Country) POLAND

10d. Inside City Limits

1 ☐ Yes 2 No

4c. County of Death

Physician
/Medical
Examiner

1 - For State Registrar

10a. State

SOPHIE 4a. Facility Name (If not institution, give street and number)

10b. County

NORTHWEST

215-30-3601

Usual Residence of Decedent

5. Social Security Number

Funeral Director

	2 -	# 1	MD BAL	IIMURE	Ρ.	IKESVILLE				X
	r 28	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	3a o	9	8911 REISTERSTO	WN ROAD			21208			USA
	eath na 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Decedent of h		fv Yes or No-	14. Race - Ame	
	iten iten	٦	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cub	Hispanic Origin? (Specit an, Mexican, Puerto Ric	can, etc.)	Black, White	
36	s af	2	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	,	1 □ Yes 2 🛣 No	Specify:		Specify:	WHITE
8	hour	<u> </u>			100	December 11 mars 1 Oceans		405	Kind of Business	1-4
Ŗ	"nat	ete	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	100	. Kind of Business/	industry
2	ne.	E C	Elementary/Secondary (0-12)	College (1-4or 5+)) 11	OUSEWIFE	(d)	Oh	NN HOME	
'n	ygie ygie her t	Completed by	12		110	JUSEWIIE	10.14.11.11.11.11.11.11.11.11.11.11.11.11.			
nd	tal H d otl	Be	17. Father's Name (First, Middle, Last	,			18. Mother's Name (/	⊢irst, Middie, Maid		
Maryland 21215-0036	Men Men arke	2	JOSEPH		L	ERNER	RACHEL		(U	NKNOWN)
a	and and le m		19a. Informant's Name/Relationship		1	Mailing Address (Street				
	and alth		DEBORAH FORD /	DAU-IN-LAW	1.	114 BELLEMO	RE ROAD - B	BALTIMORE	i, MD 212	10
ē	iten iten		20a. Method of Disposition		20b. Place of cemeter	Disposition (Name of y, crematory or other pla	(ce)	e 20c	. Location - City or	Town, State
Ĕ	Page ent c nt: If ry or		1 ABurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci			CEMETERY	08/30/	2005	ROSEDALE	. MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the M Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f any injury or other traumatic event, the Medical Examment and the ricitia and other traumatic event.		21. Signature of Funeral Service Lice			22. Name and Addre			N & BROS.	
ã	permi Depa impo any is		Death M.	ettler.		8000 PETS	TERSTOWN RO			
			23a. Part1. Enter the disease, or con	plications that caused the	he death. Do n				COVILLE	Approximate
г			shock, or heart failure. List only Immediate Cause (Final	one cause on each line).					Interval Between Onset and Death
	Physician		disease or condition resulting in death)	_ a	MON		DEMA			
r	/Medical Examiner		100011119 111 000111)	Due to (or as a	consequence	of):				
	Examine		Sequentially list conditions,	b						
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	or):				
	acute ind trans	am	that initiated events resulting in death) Last	c						
o	e ex ian a		resulting in death) Last	Due to (or as a	consequence	of):				
Box 68760,	ate b nysic he b	ca		_ d						
3	sath certificate be executed attending physician and for use as the burial-transit	Med	IF FEMALE:							
õ	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 □Ectopic pregnanc	v		23d. Date of del	
Щ.	dea ne at	100	in the past 12 months? 1 ☐ Yes 2 ☑No	4☐Pregnant at til		5 Other (specify)			Month	Day Year
P.0.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	9 Unknown						1	
ń	s the	by F	Part II. Other significant conditions				ven in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
of Vital Records,	quire an sig	Completed by	ACUTE R	ENAL	TAIL	-OILE		1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Dunknown
00	w re s bee	let						24a. Was an	24b. Were au	topsy findings available
Re	he ta b has	m						autopsy performed	l? death?	completion of cause of
a	n: T ficat r, pa	ŏ						1 ☐ Yes 2 🖸	No 1 ☐ Yes	2) 3 No
₹	hysician: his certifica	Be	25. Was case referred to medical examiner?	Hospital:	-5-5-10	Ott	26. Place of Death (
ō	Phys this ral di	To .	1 Yes 2 PNo	179 Inpatient 28a. Date of Injury		patient 30 box	4 Nuising Home		6 Other (Spec	cify)
	ing After uner	lon	27. Manner of Death 1 Pending 5 □ Pending	(Month, Day		njury Wo	rk?	d. Describe how i	ijary occurred	
Si	Attending in death.	cat	2 Accident investigation 3 Suicide 6 Could not to		411]Yes 2 □No	()		
Division	or At after of Direct in by	Certification	4 Homicide determined	building, etc.		rm, street, factory, office	28	City or Town, S	t and Number or Ru tate)	ırai Houte Number,
	ra C									
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of a	examination and	, death occurred at the ti	ime, date and place, and opinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	the lin 2, the lin 2, the lin 1,	led	one)	and manner state	ed.					
	5 til V i	Σ	29b. Signature and title of certifier			29c. Licen			Date signed (Monta	_
)	4		1		2		4352		UCUST :	
	101		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, Print) Miss	CEA TODO	12		
	1.		30. Name and address of person who	+COS PITA	L suc	OLD COU	RT ROAD	RANDA	LLS TOWN	1 4 D 5 1133
	Sta	ite	31. Date filed (Month Day, Year)	32 Hegistrar	r's Signature					
	Regist	ar	011 017	005	. A.	fresh !				
DI	HMH 17 Rev 1/2	001			100	1				
					and you a c					

+COSPITAL

6. Sex

1 □ M 2 🕅 F

		1	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of Hertificate of L				Reg. No.	2005	28559
П	Physicia	an	 Decedent's Name (First, Middle, L Mabel Hill 	ast)					2. Date of De Month August	Day	2005	3. Time of Death 1:15AM M
	/Medic Examin		4a. Facility Name (If not institution, g. Larkin Chase Nu			4b. City, Town, or Bowie				4c.	County of Death	
	Funeral Director			Sex 7. Ag 1 ☐ M 2 ☐ F	je (In yrs. last birthday 103 Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March	19°,1	902 Clar	RSburg, WV
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	e Maryl	ctor	DC None		Washingto	on,						1√ Yes 2 No
	with th	i Dire	10e. Street and Number 3298 Ft. Lincol	n Drive		10f. Zip Code 20018					zen of What Cour nited St	
	r death	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Ori n, Mexicar	igin? (Spe	cify Yes or No Rican, etc.)		14. Race - Americ Black, White,	can Indian,
036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show deal Examinational be rediffed at	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:	No	1 ☐ Yes 2 No	Specify:				Specify: Bla	ıck
15-0	n 72 ho n "natur	Completed	15. Decedent's (Specify only highest g	rade completed)	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired;	uring mos	at of worki	ng	16b. Kii	nd of Business/In	dustry
212	filed within Hygiene.	Comp	Elementary/Secondary (0-12)	College (1-4or	5+1	ails Sales					tore	
land	id be filk ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, La: Charles James A						(First, Middle, Rosa	, Maiden	Sumame)	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other then. or other traumatic event, the Marical Examinational be notified at	-	19a. informant's Name/Relationship I feu la Fana/ N	(Type, Print)	19b. Mail 1330	ing Address (Street a	nd Numbe dia l	e <i>r or Rura</i> Lane	Upper	er, City oi Mar 1	r Town, State, Zip boro, MD	Code) 20772
Baltimore,	Pages 1 ar nent of Hea ant: If item: ary or other	3.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	·	amatory or other place			ate	20c. Lo	cation - City or To	own, State
Itim	t. Partmer	ı	* 4 ∑Donation 5 ☐ Other (Specal Service Licenses)	eify)	Howard 1	Medical Sc 22. Name and Addres	hool	8/22	2/05	Was	hington,	DC
B	permi Depa Impo eny ir		0/9	(1)			38	821 1	<u>.4th St</u>	reet	NW Wash	ington.DC
	Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	y one cause on each I	ine.			cardiac o	or respiratory a	rrest,		Approximate 011 Interval Bahase 11 Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	sclerotic sa consequence of):		ase					
	ME I	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		C Arrythmia a consequence of):	ì						
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	e to Thrive a consequence of):	9						
8760,	cate be ex chysician the buria			d								
.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				1	23d. Date of deliving Month	ery Day Year
s, P	es that thighed by be detac	by	Part II. Dther significant conditions	contributing to death t	but not resulting in the	underlying cause give	en in Part i	1.	23e. Did 1		ise contribute to t No 3 □ Prot	the cause of death?
Vital Record	≥ 0 0	ompleted							24a. Was	an	24b. Were auto	opsy findings available ompletion of cause of
al Re	The ate h page	0								ormed?	death?	
ſ Vit	> 0 0	o Be	25. Was case referred to medical examiner? 1 Yes 2 YNo	Hospital: 1 Inpati	ient 2 ☐ ER/Outpati	ent 3□ DOA Othe	20	-	n <i>(Check only o</i> me 5 ☐ Resi		6 □Other (Special	fy)
on of	Jing Ph n. After th funeral	ion: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injury	Work	≀at c? Yes 2□		28d. Describe	how injur	y occurred	
Division	el or Attending P s after death. il Director: After t ed in by the funera	ertification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of Ir	njury - At home, farm, s		103 2		28f. Location (City or To			al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in the compl	0	29a. Certifier 1 Y Certifying	Physician: To the best		ath occurred at the tim	ne. date ar	nd place	and due to the	cause(s)	and manner as s	stated.
	To the Hos within 24 h To the Fur completely	ledical	(Check only 2 Medicel Ex	eminer: On the basis of and manner s	of examination and/or	nvestigation, in my or	oinion, dea			date and	place, and due t	to the cause(s)
)	To the within 2 To the comple(M	29b. Signature and title of certifier	Mas	10.19 M	29c. License D201					e signed (Month, gust 30,	
•			30. Name and address of person w	o completed cause of	death (Item 23a) (Type	e, Print)	D .		00===			
	St	ate	Rakesh Aurora 31. Date filed (Month, Day, Year)		00 Gallant ar's Signature		Bowie	e, MD	20715	Sui	te #221	
	Regist		SEP 0 1	2005	ar's Signature	COBEL						

State of Maryland / Department of Health and Mental Hygiene 2005 28560 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 29, 2005 Rache1 Α. August 4:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **EDENWALD** Towson **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb. 12, 9. Birthplace (State or Foreign Country) 2, 1924North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Funeral Days Hours 1 □ M 2 KF 240-28-8317 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show th and Mental Hygiene. 27 is markad other than "natural", or Items 23a or 28a-f shov treumatic event, tha Medical Examinat must be notified at 1 Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 800 Southerly Rd. 21204 Apt. 217 Completed by Funeral Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rev. William Thomas Brown Fannie Jane Casey ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Samala Hocutt/daughter 5028 Dogwood Place, Charlotte, N.C. Health item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 09/03/2005 Saters Baptist Lutherville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Stephen Coster 1050 York Road, Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consec **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con-Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 21**3**No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No ဥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and itle of certifie rson who completed cause of death (Item 23a) (Type, Print) imprielius 31. Date filed (Month, Day, Year) 32. Regis#ar's Signature State 2005 Registrar

		For State Registrar	State of M	Marylan			nt of He		and M		Reg. No.	200	5 285	6
Physici /Medic		Decedent's Name (First, Middle, I	John	Ε.	Ham	i1to	n			2. Date of De Month August	Day	Year 2005	3. Time of Death 2:45 A	
Examin		4a. Facility Name (If not institution, g	ive street and number	er)		4b. City	, Town, or	Location of	of Death		4c. C	ounty of Dear	h	
		2618 Greenspri			1 4 5 45 4		oppa or 1 Year	If Under	24 Hrs	0.0		arford		
Funeral			Sex 7 1X M 2 ☐ F	. ,	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da			hplace (State or Forei	gn
Director		217-12-3290 Usual Residence of Decedent	1	83						Jan.16	,1922	Ma	ryland	
yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limit	ts
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow any Injury or other traumatic avant, the Medical Examinar must be multiled at ODCs.	ç	Maryland	N/A				Ва	1timo	re (City			1 XYes 2 N	10
or 28	Funeral Director	10e. Street and Number				10f. Z	ip Code				10g. Citize	n of What Co	ountry?	
238	ra I	5911 1/2 Ayle						212				ted St		
E an	n.	11. Marital Status 1 Never Married 200 Married	12. Was Decede Armed Force	s?	.5. 13.	lf Yes, sp	ecify Cubar	n, Mexicar	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Ame Black, Whit		
alf, or	by F	3 Widowed 4 Divorced	I NAYes 2 If Yes, Give Year or Date	ੁ⊪⊽ ≶: 19 ⊿ 3	-46	1 🗌 Yes	\$CXNo	Specify:			S	pecify:	White	
in i	ted	15. Decedent's	Education		16a, Dece	dent's Us	ual Occupa	tion	t of work		16b. Kind	of Business		
. La	Completed	(Specify only highest s Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	ork done d use retired)	uning mos	t or work	nig.				
t, the	Son	12 Years			S	ales:	man						Supplies	
avan	Be	17. Father's Name (First, Middle, La								e (First, Middle,		итате)		
narka	ဥ	George E. Hami			10h Maili	^ - - -	- /Ct-sts		nma	al Route Numbe	Queen	Town State	7:- Codel	
7 le r	1 3	19a. Informant's Name/Relationship Mrs. Ann T. Ham		Vife)		-	eensp:						nd 21085	
tam 2		20a. Method of Disposition		20b. 1	Place of Dispo	osition (Na	ame of	- 1		Date	20c. Loca	ation - City or	Town, State	-
y or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		118	cemetery, cre. anev. V				ns. ^c	/1/200	5 Ti:	monium	- MD	
in ju		21. Signature of Funeral Sevice Lice		pul	2:	2 Name a	nd Addres	s of Facilit	h				,	
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vsician and ledical aminer transit	Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, was a property of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Demen Due to (or b. Hyper Co.	h line.	quence of): On		oe or dying	y, such as	cardiac	л гозрігаюту а	1651,		Approximate Interval Between Onset and Death 1 Year 2 Years	
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d be de	þ	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the u	ınderlying	cause give	n in Part I			obacco us Yes 2∑		the cause of death?	
shoul	Completed									24a. Was	an	24b. Were a	utopsy findings availab	ole
certificate has rector, page 2	mo									autor perfo	rmed?	death?	completion of cause o : 2□ No	A.
rector, p	Be	25. Was case referred to medical						26. Place	of Deat	h (Check only o			Daughter	¹s
S D	2	examiner? 1 ☐ Yes 2∕CXNo	Hospital: 1 ☐ Inp	atient 2] ER/Outpatie	nt 3 🗆 🛭	Othe Othe	ar: 4□ Nu	ursing Ho	me 5□Resi	dence 6	Other (Spe	cify)Residence	e
ner		27. Manner of Death 14 Natural 5 ☐ Pending	28a. Date of (Month,	njury Day Year)	28b. Time o	of	28c. Injury Work	at c?		28d. Describe	how injury	occurred		
the fu	cati	2 Accident investiga 3 Suicide 6 Could no	the			М		Yes 2 🗌						
ad in by the fu	Certification:	4 Homicide determin	ed 286. Place of	njury - At I , etc. (Speci	nome, farm, st ify)	reet, facto	ory, office			City or To		Number or H	ural Route Number,	
ely fille	edicai (29a. Certifier (Check only one) 29a. Medical Exp	Physician: To the bo caminer: On the back and may ne	s of examin	owledge, dea ation and/or in	th occurre nvestigation	dat the tim on, in my og	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause(s)	
To the complet	M	29b. Signature and title of certifier	M			2	9c. License	number			29d. Date	signed (Mon	th, Day, Year)	
		\	1411/				D447	793			Aug.	29, 2	005	
itl		30. Name and address of person was Ali Sanai, M.D.	L Mr	of death (Ite 1abiro	m 23a) (Type d Avenu	, Print) 1e	Ba1t	imor	e, M	aryland	212	22		
Sta	ate	31. Date filed (Month, Day, Year)	32. Reg											
Regist		SE	P 0 1 2005	Bla	ature	J. A								

			1 - For State Registrar	State of Maryland		artment of H			ene g. No 2005	28562
E	Dharini		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physici: /Medic		EARL HE	FLIN				AUGUST		
	Examin	er	4a. Facility Name (If not institution, give si			4b. City, Town, or	_	th	4c. County of De	
			2918 WELLS 5. Social Security Number 6. Sex	AVENUE 7. Age (In yrs. I	ant histograph	EDGEN		Data of Birth	1	ore Co.
	Funeral Director		213-07-7182	M 2□F 95	Yrs.	Months Days	Hours Min		rear) (irthplace (State or Foreign Country)
	ס		Usual Residence of Decedent					Judiy 23	,1910 V	irginia
	nylan how	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	8a-f	Director	Maryland Balt:	imore			Ed	gemere		1 ☐ Yes 2 🖾 No
	with the	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	eath v	era	2918 Wells Avenue	2. Was Decedent Ever in U.	C 12 1	Mas Decedent of His	21219		United St	ates nerican Indian.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other than "natural", or Items 23a or 28a-1 ehow or other treumetic event, Ite M. dical Ex. other must be notified at	by Funeral	1 Never Married 2 Married 3X Widowed 4 Divorced	Amed Forces? 153Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2X No	Specify:	to Rican, etc.)	Black, Wr	
9	72 ho	Completed by	15. Decedent's Educ (Specify only highest grade	ation		dent's Usual Occupa kind of work done d		rking 1	6b. Kind of Busines	
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	Dring most of we	rking		
12	filed w Hygier other th		7 Years			Steelwor		(5)	Steel I	ndustry
anc	I be fi	Be	17. Father's Name (First, Middle, Last) Cornelius Conway	Poflin				me <i>(First, Middl</i> e, <i>M</i> na Frances		
Z	2 should be and Mental remetic every	ို	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a		ural Route Number,		Zin Code)
	nd 2 salth ar		Mr. Earl J. Hefli		1	Capland C		erry Hall,		. ,
re,	of Health item 27 I		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	I		Oc. Location - City	
altimore,	Page nent c ant: If		XXBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		of Faith	· 1	30/2005	Baltimor	e, Maryland
Balt	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other ance.		21. Signature of Funeral Service License	n assey	D		Funeral	Home of I		Inc. 21222
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	arrhythn	nia					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ						
	LAdminer	<u></u>	Sequentially list conditions, b.	Due to (or as a consequ	ionan of):					
7	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Cleases or riju.) that initiated events	Due to (or as a consequ	derice or):					
v ~	execun and all-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					!
8760,	icate be executed physician and s the burial-transit	dlcat	d							
9	rtifica ng ph	Medi	IF FEMALE:							
Вох	that the death certificed by the attending properties as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
0	the deay y the a	yslc	1 Yes 2 No	4□Pregnant at time of de 9□ Unknown	∍ath 5□	Other (specify)			Worth	Jay , ear
۵	es that ti gned by be detac	/ Ph	Part II. Other significant conditions con	tributing to death but not resu	alting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	se. ign bed	d by						1 ☐ Yes	s 2 □ No 3 □ I	Probably 4 Dinknown
00		Completed						24a. Was an	24b. Were	autopsy findings available
Re	9 4 9	шо						autopsy	ed? death?	
Vital	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only one		20010
of V	8 ≤ E	To	examiner? 1 Yes 2 No		ER/Outpatier		4 Nursing i	Home 5 Resider	nce 6 Other (Sp	ecify)
o u		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe how	w injury occurred	
isic	Attending r death. sctor: Afte	Icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of Injury. At he			'es 2 □ No	Opt Location (Ctm	ant and Number of	Sum I Florida Muselanda
Division	l or Attendater death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, ractory, once		City or Town,		Rural Route Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	icien: To the best of my kno-	wiedge, deati	n occurred at the tim	e, date and plac	e, and due to the car	use(s) and manner	as stated.
	To the Hospital or Attenwihin 24 hours after death To the Funeral Director:	edical	(Check only 2 Medical Exemin	er: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my op	inion, death occ	urred at the time, da	te and place, and du	ue to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	, ,		29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
)			James L	mach		D000	2037	A	Jaust 2	9 2005
	10		30. Name and address of person who co	mpleted dause of death (Item	0		1- P. 1		212-1	
	Sta	to	31. Date filed (Month, Day, Year)	32. Figistrar's Signa	ture	THEFT - TON	cie Walti	em nom	46616	
	Registr		SEP 0 1 20	05 Rollies	H A	in the				

			1 - For State Registrar	State of Marylan		partment of I <i>ertificate of</i>			giene/ Rag. No.	2005	28563
	Physici /Medic		1. Decedent's Name (First, Middle, La	4. Himmel	hoc	4		2. Date of De. Month Aug		Year Z S O S	3. Time of Death 4. oc A M
	Examir Funeral Director		4a. Facility Name (If not institution, giv LOVING LIVING 5. Social Security Number 6. S 213-26-1633	e street and number) Assisted livin	us Hor	4b. City, Town, of the control of th		8. Date of Birt (Month, Da	th ly, Year)		one (State or Foreign
	f show	tor	Usual Residence of Decedent 10a. State 10b. County	more 10c. Cit	y Town or	Location v dalk		rigisi		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n with the 23a or 28a set be rolli	al Director	10e. Street and Number 25 Dundal	k Avenue		10f. Zip Code	222		10g. Citiz	en of What Cour	ntry?
036	c should be thed within 7.2 hours after beath with the maryland and Mental Hygiene. Is marked other than "naturel", or Itams 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 WNo If Yes, Give Year or Dates:	.S. 1	3. Was Decedent of I If Yes, specify Cub		ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: W/	
21215-0036	nied within 72 ho Hygiene. Sthar than "natur ant, the Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. De (G life	cedent's Usual Occu ve kind of work done b. DO NOT use retire	during most of work ed)	sing	_	d of Business/In	-
2	snould be tried wind Mental Hygiel was marked other ti	To Be C	17. Father's Name (First, Middle, Last, Herbert C	n			18. Mother's Nam	11.	Maiden S	11	
e, Mar	コモト		19a. Informant's Name/Relationship (Rando/ph Gros	IN - SON	82	ailing Address (Street 28 Long position (Name of	19 POIN	Pal Route Number	Bal	to, ma	21222
Baltimore,	tment o		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specifications) 21. Signature of Funeral Service Lices	Removal from State Ho	cemetery, o	PEMOTICAL 22. Name and Address	Park 9/2	2/05.	Bil.	hmole	mb
Ba	Depar Impor		Deter S. O	sect-	h. Do not	Bradley 2134 K	1-Ash ton	Dring A	Ral Rd.	Home 21222	Approximate
	nysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a	-a						Interval Between Onset and Death 5 years
	physician and street transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o							
.O. Box 68	ath certil titending or use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		2:	3d. Date of delive	ery Day Year
rds, P.	w requires mat the de been signed by the a should be detached t	Completed by Physici	Pan II. Other significant conditions of	contributing to death but not res	ulting in the	underlying cause gr	ven in Part I.		obacco us Yes 2	-	ne cause of death? ably 4 □Unknown
		Complet			_			24a. Was autop perfo 1 Yes		24b. Were auto prior to cor death? 1 ☐ Yes	psy findings available mpletion of cause of
Division of Vital	to the nospinal of Attending Frigstoan. The far within 24 Market and a within 24 Market bis certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Peath Natural 5 Pending investigatio 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	28b. Time Injur	of 28c. Inju		ome 5 - Resid 28d. Describe h	dence 6 now injury	ther (Specify occurred	Fecility
DIA	purs after ours after in aral Dirac		4 Homicide determined	building, etc. (Specification)	y) 		ime date and place	City or Tox	vn, State)		
-	or the nospiral of Attenda within 24 hours after death. To the Funaral Director: A completely filled in by the fo	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of examina and manner stated.	tion and/or	investigation, in my	opinion, death occur se number	red at the time,	date and p	signed (Month,	Day, Year)
	Λ		30. Name and address of person who	and the second second		pe, Print)	75157	Λ -	Aug	130,7	2005
8	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 1	McNChne 32. Registrar's Signa 2005		Hays	26) tem	The !		~11,1	y 21214

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28564 1 - State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year : 05 AM 2005 Tatricia 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death More City if Under 24 Hrs. 8. Date of Birth Min. (Month, Day, University of Maryland
5 Social Security Number 6 Sex Baltimore NIA Medical Cente If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 49 1 M 2 F 220-66-5085 WASH. 9-27-1955 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 HYes 2 No HRUNDEL ANNE MD. LOTHIAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5113 Sands 20711 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐Yes 2 No fYes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BUACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ARKER WALTER HENRIETTA 19a. Informant's Name/Relationship (Type, Print) lyb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANSFIELD HURLDY (HUSBAND) 5113 SANDS KD. COTHIAN MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CEM 9-2-2005 KESURRECTION MD. MORTUARY 1.4. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility REESE eral Service License Des ANNAPOLIS 821 WEST ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra Abolominal Days disease or condition resulting in death) Due to (or as a consequence of): Bowel Multiple Weeks Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) I □ Yes 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

as the burial-transit

attending physician for use as the buria

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s after death.

• Funeral Direct

completely

director,

Hospital or Attending Physician:

To the within 2 To the

The law requires that the death certificate be execu

Division of Vital Records, P.O. Box 68760

Examiner

by Physician/Medical

Completed

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Certification:

cal

Physician

Examiner

Funeral

Director

or 28a-f show

Director

Funeral

Completed

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item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or item any injury or other traumatic event, the Mudical Examina

Baltimore, Maryland 21215-0036

the Maryland

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Tes 2 No

27. Manger of Death 1 Natural 2 Accident

3 🗆 Suicide

4 Homicide

5 Pending investigation 6 □ Could not be

Hospital: 1 Inpatient ate of Injury (Month, Day Year)

and manner stated.

MD

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 🗌 No

28d. Describe how injury occurred

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier

29c. License number

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

P16689

Street

29d. Date signed (Month, Day, Year)

nominated frame of qualificities that there are Name and accrease of

31. Date filed (Month, Day, Year)

South Greene 32. Registrar's Signature Baltimore

State Registrar

SEP 0 1 2005

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

	1 - For Amend Item 18 Registrar 1. Decedent's Name (First, Middle, Las							2. Date of De	ath	005	2856
1		Johnson,	Jr.					Month Augus	t 25,	2005	2258 P M
! r	4a. Facility Name (If not institution, give	street and number)		4b	. City, Town,	or Location	of Death		4c. Co	unty of Deatl	h
	Holy Cross Hospit	tal		S	ilver	Spring	3		Mon	tgomen	ТУ
	5. Social Security Number 6. Se		In yrs. last bir	M	Under 1 Yea		24 Hrs. Min.	8. Date of Bi	rth ay, Year)	9. Birtl	hplace (State or Foreign untry)
	5//-86-/346	ALM 2UF	39	Yrs.				JAN 25	, 1966	Wash	ington, DC
	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Tow	n or Locati	on						10d. Inside City Limits
1			,,		T The						1 ☐ Yes 2√∑ No
	Maryland Montgor 10e. Street and Number	nery			WI10 10f. Zip Code	eaton			10g. Citizer	n of What Co	
	12050 Milton Str	eet				0902			US	SA	
	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was			igin? (Sp	ecify Yes or No Rican, etc.)		Race - Ame	
-	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		1				Rican, etc.)		Black, White	
	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 1	Yes 2∏N	o Specify.	:		Sp	ecify: ALa	skan Nativ
	15. Decedent's Ed		16a.	Decedent	's Usual Occ	upation e during mos	st of work	ina	16b. Kind	of Business/	Industry
-	(Specify only highest grades) Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO	NOT use reti	red)		3			
1	12			Truc	k Dri				-	nsport	ation
	17. Father's Name (First, Middle, Last)	-				18. Moth		e (First, Middle		mame)	
	Manuel Johnson,	Sr.						tha Wal			
	19a. Informant's Name/Relationship (7			•				al Route Numb			(ip Code
	Rena Littlefield I	Parker/Sist				d Driv		adson,		9456	Tawa Chata
-	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	ł .	ry, cremato	ory or other p					tion - City or	
ļ	4 ☐ Donation 5 ☐ Other (Specify	1)	Metro					0/05	Bal	Ltimor	e, MD
	21. Signature of Funeral Service Licen Round A Gre Edward A Gre	gorchik				ress of Facil		of MD.	Inc.		10
	23a. Part1. Enter the disease, or comp			1299	Frede	rick I	Road	of MD Baltim	ore, M	D Z1ZZ	28
	shock, or heart failure. List only	plications that caused the	ne death. Do							D 2122	Approximate Interval Between
l	shock, or heart failure. List only Immediate Cause (Final	one cause on each line		not enter ti	he mode of d	ying, such as	cardiac	or respiratory a	arrest,		Approximate
	shock, or heart failure. List only	plications that caused the one cause on each line a	a Due '	not enter to	he mode of d	ying, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between
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	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d. d.	a Due consequence	To Wo of):	he mode of d	ying, such as	cardiac	or respiratory a	ndrome		Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) SEP 0 1 2005

RUBIO,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

		1- State of Maryland / Department of Health and Per me G847 9-12-05 tas Certificate of Death	Mental Hygie	ne 2005	28566
	sician edical	1. Decedent's Name (First, Middle, Last) Drawza Johnson	2. Date of Death Month		3. Time of Death
	niner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th re ,	4c. County of Death	sop.
Funer Direct		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs 1		9. Birthplac Country	Carolina
ith the Maryland or 28a-f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-	10d.	Inside City Limits
th with the 23a or 28a-	i Director	10e. Street and Number 1001 / en ton Avenue 212/2	10g.	Citizen of What Country	?
1215-0036 within 72 hours after death with the Maryland ene. than "natural, or items 23s or 28s-1 show a Medical Esserites frougilised at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Black, White, etc	
5-003 72 hours of matural, of allow Execution	eted by	3 Widowed 4 Divorced If Yes, Give 1 Yes 2 Specify: Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 168	b. Kind of Business/Indus	itry
nd 2121 e filed within al Hygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Life. DO NOT use retired) Topover	newt (onstru	ction
Maryland 21215-0036 d2 should be filed within 72 hours aft in and Mental Hygiene. Trig is marked other than "natural", or traumatic event, the Medical Examination of the control of the c	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name MONIDE Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)	y Ham	pton	
C = 14 F		Burnetta John Son 1001 Lewton Au 20a. Method of Disposition 20b. Place of Disposition (Warne of	e, Bala	ity or Town, State, Zip Co	42
Page Page ment o		Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	9-6-05 (Durings M	lills, MD
Balt permit. Departit Import	DOC	130 Clyto Vaugha C. Cree 4905 Yack 7	d - Bulk c of respiratory arrest,	MD UZ	Pproximate
Physicia /Medic		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		0	terval Between nset and Death
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WOF 28. 8760,ate be executed hysician and the burial-transit the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
87 ate	Medical	d	-		
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ords, P. (requires that the signed by hould be delaced)	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the c	
LOSLIN II Record The law required has been serie has been series page 2 should	Completed		24a. Was an autopsy performed	24b. Were autopsy prior to compl	
of Vital F Physician: Th this certificate	Be	examiner?	1 ☐ Yes 2 ☐ ath (Check only one)		//
On ding	ition: To	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing H 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 3 Nork? 2 Accident investigation 1 Norther: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No	28d. Describe how i		tospia
Division Division of a ster death	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	it and Number or Rural Ri State)	oute Number,
Division To the Hospital or Attention Within 24 hours after deat To the Funaral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the my knowledge, death occurred at the my knowledge of my knowledge, death occurred at the my knowledge of my knowled	e, and due to the caus urred at the time, date	e(s) and manner as state and place, and due to the	d. e cause(s)
To the within 2 To the complet	ž	29b. Signature and title of certifier 29c. License number	1	Date signed (Month, Day	
10		30. Name and address of person who co pleted cause ath (Item 23a) (Type, Print) W. A. Liley G. Binc G701 N. Charles St. B. Uto			
	State istrar	31. Date filed (Month, Day, Year) SEP 0 1 2005			

			1 - State Amend Items Registrar	State of M 7,8,9, p	laryland er FH,	C84/e	tificate of	lealth d hb Death	and M	ental Hy	giene c Reg. No.	2005	28567
	Physici	an	1. Decedent's Name (First, Middle, La: Wallace B. Kna	*						2. Date of De. August		2005 ^{Year}	3. Time of Death 10:10pm
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number			4b. City, Town, o		of Death	7109000	4c. C	ounty of Death	10.10рін
	Funeral Director				ge (In yrs. Ia	ast birthday) 2— Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birt (Month, Da June I	ր 10/3 Ց՚ֈ՟192	1/13 Birthp	ace (State of Foreign
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					11	Od. Inside City Limits
	e Mary 3e-f sh Iffied	Director	MD Howard		Co	lumbia							1 V Yes 2 No
	23a or 28	rai Dire	5400 Vantage Poi	nt Road			10f. Zip Code 21044				-	ed State	,
920	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dicel Examiner must be multised at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 [7] Yes 2 [If Yes, Give Year or Dates	?] N o	11	Vas Decedent of H f Yes, specify Cub ☐ Yes 2 No	tispanic Or an, Mexica Specify	n, Puerto F	cify Yes or No Rican, etc.)		Rece - Americ Black, White, of Specify: Whit	etc.
21215-0036	within ne. Ihan "	Completed	15. Decedent's Elementary/Secondary (0-12)			(Give . life. L	lent's Usual Occup kind of work done DO NOT use retired qement A	during mo: d)		g	0ffi	ce Of Cense Mob	
Maryland 2	be filed stal Hyg ed othe event,	To Be C	17. Father's Name (First, Middle, Last, William W. Knap)	<u>, , , , , , , , , , , , , , , , , , , </u>	Hana	gement n	18. Moth	er's Name	(First, Middle, Schofi	Maiden Si	umame)	
Aary	2 sh and Is m	_	19a. Informant's Name/Relationship (g Address (Street						
	s 1 and if Health item 27 other tr		Malcolm R. Knap 20a. Method of Disposition	p (Son)	20b. Pla	ace of Dispos	Butterw sition (Name of	1		ithesb		MD 2088 ation - City or To	
Baltimore,	Pages ment of I ent: If its jury or o		1 Burial 2 Cremation 3 Removal from State '4 Oponation 5 Other (Specify) Howard Medical School 8/(21 Signature of Euperal Service Licensee							05	Wash	ington,	DC
Ball	permit. Pages: Department of H Importent: If ite any injury or of		21. Signature of Euneral Service Licensee 22. Name and Address of Facility Austin Royster Funer 3821 14th St. NW Was							ral Ho	me on D	nc 20011	
			23a. Part1. Enter the disease, or com shock, or heart allure. List only	plications that cause one cause on each	the death. line.	. Do not ente	er the mode of dyin	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Bilate	ral Pi		ia						
	Examiner	Je.	Sequentially list conditions, if any, leading to immediate	b. Corona Due to (or a	ry Ar	tery D	isease						
V	and transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Chroni	c Obs	tructi	ve Pulmo	nary	Disea	se			
68760,	licate be executed physician and s the burial-transit	edical E		_ d.	s a consequ	ence or);							
O. Box	The law requires that the death certific to has been signed by the attending p tage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	<i>y</i>			230	d. Date of delive Month	'Y Day Year
Φ.	n requires that been signed b should be deta	by	Part II. Other significent conditions of Valvular Cardeo		but not resul	lting in the ur	nderlying cause giv	en in Part	1.				e cause of death?
I Records,		Completed								24a. Was autop perfor	med?	24b. Were autop prior to con death? 1 Yes	sy findings available apletion of cause of
Vital	Physicien: this certificated director, I	o Be	25. Was case referred to medical examiner?	Hospital:	uont 2□E	D/Outration	oth Oth	on		(Check only o			
of	aling Phys	1 Mnpatient 2 Envoying Home 5 Residence 6 Other (Specify))			
Division	D E d to a 2 Accident investigation M 1 ☐ Yes 2 ☐ No							Number or Rural	Route Number,				
	Hospitel 4 hours Funerel iely filled	edical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	nysicien: To the bes niner: On the basis and manner s	of examination	rledge, death on and/or inv	occurred at the tirestigation, in my o	me, date a ppinion, dea	nd place, a ath occurre	nd due to the o	cause(s) ar date and pl	nd manner as sta lace, and due to	ated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of centuer	et) u	D		29c. Licens					t 3, 200	
•	3		30. Name and address of person who 300 Armory Place				erint) Kenne	eth Ge	eh, M		943	5 5, 20	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 1	32. Regis	trar's Signati		A						

State of Maryland / Department of Health and Mental Hygien 20528568 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 4a. Facility Name (Il not institution, give /Medical street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 7. Age (In yrs. last birthday)
Yrs. 9. Birthplece (State or Foreign Country) MARY LAND 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 F Months Hours Min. 219-16-4916 Director aa/25 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f shov the Medical Examinar mant by notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 265 NITED within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: UNK 1 ☐ Yes 2 ☑ No Specify: WHITE þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider) Pages 1 and 2 should be nent of Health and Mental HRISTANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other p H Item 27 Date 20c. Location - City or Town, State PAULA RUSH/DAUGHTE PEERY DR. other Baltimore, 20a. Method of Disposition or other place) 1 ☐ Burgal 2 ☐ Cremation 3 Removal from State ö permit. Pag Department Important: It eny injury or once. ANATOMY GIFTS REG 9/29/05 4 Donation 5 Other (Specify) HANOVER, MD 22. Name and Address of Facility 21. Signature of Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or emplication that caused in shock, or heart failure. List only one arms on each line. date death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown à ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🔲 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has 1 🗌 Yes 2/2 No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: ٥ 1 Yes 20 No 2 FR/Outpatient 3 DOA Jursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 DNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide hours after ŏ within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - State Registrar amend ite	State of Maryland / D m # 13&14 PER FH G	847rin Late 97	Death		No.2 0 0 E	20560
			1. Decedent's Name (First, Middle, Las	•			2. Date of Death Month	Day Year	不過999 2
	Physici /Medic		DOROTHY	MERRITT			AUGUST	27 200	5 2:00AM
	Examin	_	4a. Facility Name (If not institution, give			or Location of Death		4c. County of Dea	th
	<i>*</i>			PITAL LENTER		If Under 24 Hrs.		n/a	
	Funeral		5. Social Security Number 6. Security Number 1	□M 25KF	frs. Months Days	Hours Min.	(Month, Day, Ye		thplace (State or Foreign country)
來.	Director		Usual Residence of Decedent	75			May 10, 19	30 Mary	land
	yland		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	a-f sl	ctor	MD Baltimore	Catons	ville				XĕYes 2□No
	or 28	Olre	10e. Street and Number		10f, Zip Code		10g.	Citizen of What C	ountry?
	ath w	rail	6 Stuart Mills Pl	Y	21228			USA	
	er de Items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	Hispanic Origin? (S) an, Mexican, Puerti	pecify Yes or No- o Rican, etc.)	14. Race - Ami Black, Whi	encan Indian, te. etc. Black
36	irs aft	by Funeral Director	3 ₩ Widowed 4 □ Divorced	1	1 ☐ Yes 🔏 😾 No	Specify: wh:	i t e	Specify:	white
215-0036	within 72 hours after death with the Maryland ene. than "natural", or llems 23a or 28a-f show than "natural", or liter must be notified at		15. Decedent's Ed	ducation 16a.	Decedent's Usual Occup	pation	161	o. Kind of Business	/Industry
215	thin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of world)	King		
N	filed with Hygiene other tha ant, the h	Completed	8th	Coo	k	T	St	. Mary's	Seminary
nd	d oth	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Mai	den Sumame)	
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Maryland	12 sho h and 7 is mu trauma		19a. Informant's Name/Relationship (7		Mailing Address (Street			•	
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show then traumatic event, the Marikal Examination motified at		Gloria Merritt- D	aughter 6 1	Stuart Mf11 Disposition (Name of y, crematory or other pla	s Pl. Cat	onsville	110 21225 Location - Try or	Town, Slate
10	nant of He ant: If iten ury or oth		to Burial 2 ☐ Cremation 3 ☐	Inditional Hotti State					
Baltimore,	artme artme ortani injury		*4 □ Donation 5 □ Other (Specify 21. Signal I of Funeral Service Lon		ill Cemeter		1, 05 Broad and Park	ooklyn Pa	ırk
Ba	Department of Bearing of Bearing of Bearing of Bearing of Section 19 Concession 19 Con		thing Ac.	hlanaus	3620 Wilke				
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	Pnysician		Immediate Cause (Final	one cause peach line. METASTATI			NCER		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of		31 011	10001		6 YEARS
87	Examiner		Conversion to the sounditions	ACUTE R	ENAL	FAILL	RE		2 DAYS
ш	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of					2000
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687	physi the l	dlcal		. d					
× 6	death certificate be executed e attending physician and ad for use as the burial-transit	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of de	livery
Вох	atter after of for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnand 5 ☐ Other (specify) _	у		Month	Day Year
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٦,	uires that the der signed by the a Id be detached f	by P	Part II. Other significant conditions o	ontributing to death but not resulting in	the underlying cause gr	ven in Part I.	23e. Did tobac	co use contribute t	the cause of death?
rds	w require been sig should b	ed b					1 Tes	2 No 3 P	robably 4 dunknown
Records,	law requires as been sign 2 should be	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ä	The te h age	E O					performed	death?	
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
of V	nysic nis ce I dire	To	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Out	tpatient 3 DOA		ome 5 Residence		cify)
			27. Manner of Death	28a. Date of Injury 28b. T (Month, Day Year) Ir	ime of 28c. Inju		28d. Describe how i	njury occurred	
n o	ing PI	:uo	Natural 5 ☐ Pending			No			
sion o	Jing After fune	catlon:	2 Accident investigation	n	M 1]Yes 2□No	20f Loanting /Ctma	t and Number of O	umi Pouto Numbos
division o	or Attending Pt ifter death. Director: After th in by the funeral	ertification:		n	M 1]Yes 2□No	28f. Location (Stree City or Town, S		ural Route Number,
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Division	To the Hospital or Atter within 24 hours after deat To the Funeral Director completely filled in by the	te į	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier About 30. Name and address of person who ABDUL ADJE! 31. Date filed (Month, Day, Year)	28e. Place of Injury - At home, far building, etc. (Specify) aysician: To the best of my knowledge miner: On the basis of examination and and manner stated. Completed cause of death (Item 23a) (M 1 [rm, street, factory, office death occurred at the todor investigation, in my 29c. Licen R E	me, date and place opinion, death occurse number	, and due to the caus rred at the time, date 29d.	e(s) and manner a and place, and during Date signed (Monius Cuus 2)	s stated. to the cause(s) th, Day, Year) 7, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 17 per fh 8847 9-1-05 vt.

State of Maryland / Department of Health and Mental Hygiene 2005 = For State Registrar 28570 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 30, Day 2005 Year **Physician** William D. Martindill 10:30AMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5906 Carlton Lane Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Year) | 9. Birthplace (State or Foreign Washington, DC 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months 1 □ M 2 □ F 75 Yrs Director 577-36-5984 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 le marked other then "naturel", or items 23a or 28e-f show other treumatic event. the Wodical Exam, nor must be collided at 1 X Yes 2 □ No MD Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 Carlton Lane 20816 United States Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 [V] Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. out: If item 27 le marked other then Elementary/Secondary (0-12) 2 years Mortgage Loan Officer Riggs Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ann S. Martindill Winfield Scott Martindill Beulah Darbie Martindill ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann S. Martindill Wife 5906 Carlton Lane Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If any injury or once. ' 4 Donation 5 ☐ Other (Specify) <u>Howard</u> University 8/17/05 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austina Royster Now Washington, DC 20011 23a. Part1. Enter in Isease, ir complication, their caused in shock of art failure. List only one cause on each line. Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Impediate Luse (Final Sease or condition resulting in death) **Physician** Mestastic Cancer Of Pharynx /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? ector: After this certific by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5y Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of contrier 29d. Date signed (Month, Day, Year) 29c. License number August 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahryar Davari, M.D. 8609 Second Ave. #404B Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2005

		1	For State Registrar		State o	f Marylar	id / Depa <i>Cei</i>	artment tificate	of He	ealth a Death	and M	ental Hyg	giene _{leg. No.}	2005	28	571
	hysicia /Medic	al .	1. Decedent's Name (First Elizab	eth G.	Mart	in						2. Date of Dea Month August	26 Day	2005 ^{Year}	3. Time of 11:5	Death
**	xamin		4a. Facility Name (If not in 24 Hull 5. Social Security Numbe	Ave.		nber) 7. Age (In yrs.	last hirthday)	4b. City, 1 Anna If Under	poli	S If Under 2		8. Date of Birth	Ar	ounty of Dea	undel	y Foreign
Dir	ineral rector	2	212-07-0619 Usual Residence of Dece	10	_M 2 ⊠ F	90	Yrs.	Months	Days	Hours	Min.	(Month, Day April 2	29 19	915 Ma	thplace (State country) aryland	, or engr
e Marylan	Sa-f show	ctor		. County nne Arur	ndel		y, Town or Lo \nnapol		-						10d. Inside C	ity Limits 2 ⋈ No
with th	3c or 2	i Dire	10e. Street and Number 24 Hull Ave					10f. Zip	^{Code} 214	П3			10g. Citiz	en of What C US		
C C I C I S-0030 filed within 72 hours after death with the Maryland Hygiene.	Important: If itam 27 is marked other than "natural", or itams 23s or 28a-f show any injury or other traumatic evant. The Mudical Examinat must be notified at 2008.	by Funeral Director	11. Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ □	2 Married	12. Was Dece Armed Fo 1 Tyes If Yes, Gir Year or D	2 No No	1	Was Deced f Yes, spec	ent of His ify Cuban		gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		Race - Am Black, Whi Specify:	erican Indian,	2
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Dallinore, permit. Pages 1 a Department of Hee	ant: If itar ury or oth		20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5	omation 3 🗆 l Other (Specify,)	State	Place of Dispo cemetery, cren celand	natory or ot	her place		ء - 31–3	-05		timore,		
permit. Departr	any in		21. Signature of Funeral 23a. Part1. Enter the dis	41 -	7 ×	5		_1050	Yor	k Rd.	. Tou	al Home uson, Mo	121	nc. 1204		
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	nysician and ne burial-transit	dicai Examiner	Sequentially list conditio if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to	(or as a consec	juence of):								•	
the death certifica	igned by the attending physician and be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	1 ☐ Live t	tcome of pregni birth 2 Peta nant at time of co	ıl death 3□	Ectopic pre					2	3d. Date of de Month		Year
	been signed b should be deta	by	Part II. Other significant	t conditions co	ntributing to d	eath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	A	/	o the cause of c	Jnknown
T Pe	ate has page 2	Completed								J		24a. Was a autop perfor 1 🗆 Yes	sy med? No	24b. Were a prior to death?	utopsy findings completion of c	available ause of
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<u> </u>	tor: After this the funeral di	ertification;	2 Ascident	Pending investigation Could not be		th, Day Year)	28b. Time of Injury	М		at ? es 2 🗆 N	No	28d. Describe h				اندو
LIVISION To the Hospital or Attanding within 24 hours after death.	To the Funarel Director: After this certific completely filled in by the funeral director.	O	4 Homicide	determined	build	of Injury - At h	fy)					28f. Location (S City or Tow	n, State)			рвег,
the Hosp in 24 ho	tha Fune pletely f	ledical	(Check hil) 21	Certifying Phy Medical Exam	i per: On the b	asis of examina ner stated.	owledge, death	occurred a vestigation,	in my op	inion, deat	d place, a	ed at the time, o	date and	place, and du	e to the cause(s	s)
Towith	To	Σ	29b. Signature and title	of certifler	DOK	-Mr)	346	License	636	,4		8 Z	signed (Mon.	in, Day, Year)	
	10		10 Name and redress	HE	ompleted bu	9001	38570	THE	K	1)30	D.	Amv	AP3	MZES	02140	
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			1- State of N	Maryland / Department of Health and	Mental Hygi	ene
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	g. N2 0 0 5 2 8 5 7 2
	Physic /Medi		Selma	Mayo	Ausust	27 2005 19:03 PM
	Examir		4a. Facility Name (If not institution, give street and number	4b. City, Town, or Location of Dea	th 10 1	4c. County of Death
	Funeral		5. Social Security Number 6. Sec. 7.	Age (In yes jast birthday) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign
	Director		216-32-0032 1 M 2XF	Yrs. Months Days Hours Min	2-21-	29 VIEGINIA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		red. Inside City Limits
	e Mary la-f sh	ctor	MD	Paltimore,	٠	1 XYes 2 □ No
	72 hours after death with the Maryland natural', or items 23a or 28a-f show litsal Examinar must be notitled at	Funeral Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country?
	death ms 23	neral	11. Marital Status	nt Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
36	s after , or ite	by Fu	Armed Force 1 □ Never Married 2 □ Married 1 □ Yes 2 ₽ If Yes, Give	No 1 ☐ Yes 2 No Specify:	to Hican, etc.)	Black, White, etc. Specify: Place P
21215-0036	72 hours "natural", Vical Exe	ted b	3 Widowed 4 □ Divorced Year or Date: 15. Decedent's Education	16a, Decedent's Usual Occupation	16	6b. Kind of Business/Industry
121	d within 72 ho giene. r than "natu ine Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Give kind of work done during most of world) or 5+)	rking	
	in the H	(D)	17. Father's Name (First, Middle, Last)	Housewife 18 Mother's Na	me (First, Middle, Ma	Domestic aiden Sumame)
/lan		To B	Stattord BOYD	Pear	-L Rec	250
Maryland	s 1 and 2 should Health and Meritem 27 is market othar traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R	ural Route Number, (City or Town, State, Zip Code)
-	Healt Healt tem 2	•	20a. Method of Disposition	20b. Place of Disposition (Name of	Date 20	Oc. L cation - City or Town, State
ë E	ertment of ortant: If it injury or o		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Baltimore Ceme tory	3/3/05 1	Baltingon MD
Baltimore	permit. Pa Depertmen Important: any injury		21. Signature of Funeral Service Licensee	22 Name and drees of Facility	10 FT4) 01	Al Services
	20240		23a. Part1. Enter the disease, or complications that caus	ed the death. Do not enter the mode of dying, such as cardia	O.B. Ito	t. Approximate
ı	Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	MYOCARDIAL INFARCT		Onset and Death
	/Medical Examiner		resulting in death) Due to (or a	as a consequence of):		1 Mour
		ē	Sequentially list conditions.	ARTERIOSCLEROTIC CARDIOVA	ISCULAR D	ISEASE 5 16915
	icate be executed physician and s the burial-transit	Examiner	that initiated events			
8760,	be executed ician and burial-transit		resulting in death) Last Due to (or a	is a consequence of):		
289	g physicate as the	edlcal	d			
Вох	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom	ne of pregnancy 2		23d. Date of delivery
P.O. E	the dear	ysici	1 ☐ Yes 2 ☐ NO 9 ☐ Unknown 9 ☐ Unknown	at time of death 5 Other (specify)		Month Day Year
۳.	w requires that the de been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ords	equire sen sig ould b	ted b	NASESLENTION		1 ☐ Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal	ysician: The is certificate hi director, page	e Co	25. Was case referred to medical		performe 1 ☐ Yes 2 2	d? death? No 1 ☐ Yes 2 ☐ No
Ţ	Attanding Physician: r death. actor: After this certifice by the funeral director.	ToB	examiner?		ath <i>(Check only one)</i> Iome 5☐ Residenc	ce 6 ☐Other (Specify)
0 U	ing Pt		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of In (Month, D	gury 28b. Time of 28c. Injury at Work?	28d. Describe how	injury occurred
/isic	Attand death of the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of I	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	at and Number or Rural Route Number.
ā	tal or safter al Dira	Certification;	4 Homicide determined building,	atc. (Specify)	City or Town, S	State)
	Hospi 24 hour Funar Fely fill	edical	Medical Examiner: On the basis	st of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred.	, and due to the caus	se(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or Attanding Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	->0		Nathan A Scott II	MD 20034484		8.29.05
	6		30. Name and address of person who completed cause of	death (Item 23a) (Type, Print)	.40 .402:	
	Sta	te.		1000 E. EAUER ST. BALTIM.	OKE , MITTY	LAND 51505
	Registr		31. Date filed (Month, Day, Year) 32. Regis	- K. A. O.		
DHM	MH 17 Rev 1/20	001				
				ORIGINAL		

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registrar amend item #8 28573 per ana bd g849rtificate of Death 2. Date of Death Month **Physician** 18, 2005 7:48 PM M August Eleanor M. Mitten /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 E. University Parkway #803 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 87 Oct 18,1917 New York Director 350-09-1518 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other traumatic event, Ite Marafael Extractor into institute a page. 1X Yes 2 □ No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 E. University Pkwy # 803 21218 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 24 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates: WW II Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Secondary (0-12) College (1-4or 5+) Medical School librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be May Oberist Harry Mitten P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Zimmerman/friend 4200 St. Paul Street Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mount | Mount Greenmount Cemetary 9-2-05 Baltimore, MD * 4 □Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronal a S. Wade 22 Name and Address of Faculty Mitchell Wiedefeld F. Herling State Anatomy Boattchell Wiedefeld F. Herling Ballinnoie, MD 21201 6500 York Road Baltimon Baltimore, MD

Approximate 21212
Interval Between
Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYCCARDIAL INFARCTION **Physician** 52495 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPENTENSICU 1 Yes 2 40 3 Probably 4 Unknown ATRIAL FIBOLUSTICA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examine?

1 No 2 No Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 AMatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.0. Division of Vital Records,

the Maryland

Maryland 21215-0036

Baltimore.

Hospitel or Attanding Physician: The law requires that the death certificate be executed for use as the detached director, page 2 should be this the funeral After within 24 hours after death. To the Funeral Director: A filled in by completely

To the

and

State Registrar

Medical

31. Date filed (Month.

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

RMCD

30. Name and address of person who completed cause of death (Item 238) Type, Print)

mica

7505 OSIEN DINE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOC 1373

29d. Date signed (Month, Day, Year)

	•	For State Registrar	State of Maryland/	Certific	cate of Death	Reg	No. 1005	28574
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)			Myrick	2. Date of Death Month August	Day Year	3. Time of Death
Examin		4a. Facility Name (If not institution, give JOHNS HOPKINS-BAY		4b.	City, Town, or Location of De BALTIMORE	ath	4c. County of Dea	ath
Funeral Director		5. Social Security Number 6. Sep. 132 -44-6500			Inder 1 Year If Under 24 H https://doi.org/10.1001/10.		ear) 9. Bi	rthplace (State or Foreign country) ARY LAND
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD • N/A		wn or Location	1			10d. Inside City Limits 1 □ Yes 2 □ No
with the fast or 28e-	Funeral Director	10e. Street and Number 808 N. WOODINGTON			f. Zip Code 21229	10g	. Citizen of What C	ountry?
be filed within 72 hours after death with the Maryland lat Hygiene. Ad other than "naturel", or items 23a or 28e-f show event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1授Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? Wes 2000 If Yes, Give Year or Dates:	If Yes	Decedent of Hispanic Origin? specify Cuban, Mexican, Pu es 2 1 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
od within 72 hours at giene. er than "naturel", or itte Maulcal Exam	Completed I	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16	(Give kind	Usual Occupation of work done during most of w OT use retired)	vorking 16	b. Kind of Business	s/industry
id be filed w ental Hygier ked other th ic event, the	To Be Cor	-12- 17. Father's Name (First, Middle, Last) EARL MYRICK	-3-	MUSIC		ame (First, Middle, Mar		
nd 2 sho alth and 27 is mu	H	19a. Informant's Name/Relationship (Ty) KENNETH MYRIC	<u></u>		dress (Street and Number or Bridge)	Rural Route Number, C	ity or Town, State,	Zip Code) 20772 MARLBOROI
Page ment o ent: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemet	4021	To east 9-	8-05 ON	C. Location - City or	MILLS MD
permit. Deporti Importi any inj		21. Signature of Fundal Service License). Hisre	22. Nan	ne and Address of Facility	HILLIPS FI.	BALTO.	Home MD. 21217
Physician /Medical		23a. Part1. Inter the disease, or complishock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do e cause on each line. Due to (or as a consequence	, he	mode of dying, such as card	ac or respiratory arrest,		Approximate Interval Between Onset and Death 13 4 - 4 - 5
ficate be executed physician and physician and si the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury that initiate events resulting in death) Last	Tue to (or as a consequence	of):				al days
= 0.0	/We	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown		pic pregnancy r (specify)		23d. Date of de Month	livery Day Year
quires that the d	b S	Part II. Other significant conditions con	tributing to death but not resulting	in the underly	ing cause given in Part I.			o the cause of death?
or Attending Physicien: The law requires taller death. Director: After this certificate has been signe in by the funeral director, page 2 should be or	Completed	End stage 1 Peritonitis	enal diseas	ę		24a. Was an autopsy performed 1 Yes 2 🔀	prior to death?	utopsy findings available completion of cause of
hysicien his certifi	To B	1 163 2 E 110		utpatient 3[Othor	eath Check only one. Home 5 Residence	e 6 □Other (Spe	cify)
tending eath. or: Afte the fune	Certification;	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At home, f	Time of Injury M arm, street, fa	28c. Injury at Work? 1 Tyes 2 No	28d. Describe how in 28f. Location (Street)		ural Route Number.
To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	edical Certi	29a. Certifier 1 Certifying Phys	building, etc. (Specify) ician: To the best of my knowledger: On the basis of examination all	e. death occu	rred at the time, date and plan	City or Town, Si	e(s) and manner as	stated
To the F within 24 To the F complete		29b. Signature and title of certifier Gystle Brown M	and mainer stated.	naroi ilivestigi	29c. License number ### April 10 Page	29d.	Date signed (Mont	h, Day, Year)
510		30. Name and address of person who con Lynette Brown, John	mpleted cause of death (Item 23a)	(Type, Print)	O North Wal			

State of Maryland / Department of Health and Mental Hygienen 28575 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 28th, 2005 8:40 August Paul Stephen Patrici<u>an</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Brightview Assisted Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day.) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Months 77 Oct. 21, Mass. Director 014-20-6614 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes ZZINo Director Baltimore City MD n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1943 West Lombard St. 21223 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If lean 27 is marked other than "natural, or Items 23, ury or other traumatic avant, in a Medical Examinate must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Five Corners Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Mikus ပ Stephen Petrishin 19a. In ormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Petreshene - Brother 33 Graceland Dr. San Rafael, California 94901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or Cedar Hill Cemetery Sep. 1, 2005 Brooklyn Park * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. BAltimore, MAryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Stews resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicion and burial-transit The law requires that the death certificate be executed P.O. Box 68760. Due to (or as a consequence of) Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Por in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending t hours after death. Funeral Diractor: Af ely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number in who completed cause of death (Item 23a) (Type, Print) 21229 0 06 32. Higistrar's Signature 31. Date filed (Month Cary Carles State Registrar

1	-	F	i	ate agi	ra
_ ·	-				

_	State Registrar	

Physicia /Medica Examine

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any filury or other treumatic event, the Mudical Examinat must be nutified at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical **Examiner**

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 10

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Las								
	st)				2. Date of Dea Month	th Day	Year	3. Time of Death
Carol			Peirce		August		2005	07:45A
4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death	-	4c. C	ounty of Death	
Greater Baltimore	Medical Cen	iter	Towson		,		timore	
5. Social Security Number 6. S	ex 7. Age (In	978. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb 01	1922	9. Birth	place (State or Foreig SSOuri
Usual Residence of Decedent	10	o City Town as La						104 1-14 01-11
Md. Baltimo		c. City, Town or Lo Cockeys v						10d. Inside City Limit:
	71 6		-т					
705 Warren Rd.			10f. Zip Code 2	1030	1	0g, Citize	un of What Cou USA	intry?
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, pecify:	
15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occupa	ation during most of work	ing	16b. Kind	of Business/In	ndustry
Elementary/Secondary (0-12)	Colleg 5 (1-4or 5+)	Prof	PO NOT use retired Fessor	during most of work f)		Edu	ıcation	
17. Father's Name (First, Middle, Last) Charles H. Wi	lliams			18. Mother's Name	e (First, Middle, I	Maiden Su	ımame)	
19a. Informant's Name/Relationship (Diane Markert/ F	Type, Print) Triend	19b. Mailin PO	Box 9724	and Number or Rura HOIIINS	Univers	í ty or I	own State Zip Koanoke	, Va. 2402
20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify	Removal from State	Evergreen	natory or other plac n Burial	Park 9-6-	05		tion - City or To	
21. Signature of Funeral Service Licen		22	Name and Addres	ss of Facility WSOn .Fune	ral Hom	g, Įŗ	204	
10 1	15		1020 10	rk Rd. To	wson, M	u. 21	1204	
23a Part 1 Enter the disease or com-	plications that caused the	death. Do not enti-	er the mode of dvin	a such as cardiac o	or respiratory are	net		Approximate
23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	plications that caused the one cause on each line.	death. Do not ent	er the mode of dyin-	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	TONIA	er the mode of dyin	g, such as cardiac o	or respiratory arr	est,		Interval Between
shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a	ONIA ensequence of):		g, such as cardiac o		est,	٠	Interval Between
shock, or heart failure. List only Immediate Cause (Final disease or condition	a	onsequence of):					٠ - -	Interval Between
shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to finh ediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. South for an a co	onsequence of):					۲L /	Interval Between
shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to finh ediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. South for an a co	onsequence of):				50,	d. Date of delive	Interval Between Onset and Death Onset and Death ONE WEE
shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	b. Due to (or as a co	insequence of): regnancy Fetal death 3 a of death 5	Ectopic pregnancy Other (specify)	ACINO	νA, (230	d. Date of delive	ery Day Year
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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
SEP 0

CRAIG

30. Name and address of person who completed gluse of death (Item 23a) (Type, Print)

1 2005

SINGEN

6701

32. Registrar's Signature

29c. License number

CHAPLES

055643

ST,

29d. Date signed (Month, Day, Year)

BATTIMONE,

2005

	_1	Stete Registrer	State of Maryland	Certificate of		R	eg. No. 200		
siciar ledical aminei	1	Decedent's Name (First, Middle, L HERTDALTNA I Aa. Fecility Name (If not institution, gi	ENA RIPOLL CUEVA		or Location of Death		Day Yea 28, 2005	4:00 A	
eral tor			esville Sex 7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	(Year) 9. B	re County hirthplace (State or Fore Country) erto Rico	
ie de		Usual Residence of Decedent 10a. State 10b. County		Town or Location		AUE AT	, 1,1,	10d. Inside City Lim 1 ☐ Yes 2X	
Directo	Direc	10e. Street and Number 3800 Old Court		10f. Zip Code 21	208	10g. Citizen of What			
Aby Europeal Director		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cut	Specify:			merican Indian, hite, etc. White	
The Madical	Completed by	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Homemake		rking	Own Res	•	
ic even	10 86 0	17. Father's Name (First, Middle, Las Jamie Ripoll 7	irado		18. Mother's Nan Rosali	na Cuev	iddle, Maiden Surname) UEVAS		
other trauma		19a. Informant's Name/Relationship Edward M. Canino 20a. Method of Disposition	(Nephew)	19b. Mailing Address (Stree 3702 Fastwoo ce of Disposition (Name of netery, crematory or other plane	d Drive.	Baltimo	r, City or Town, State re, Maryl, 20c. Location - City	and 21206	
any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Co.	Gree	en Mount Crema 22. Name and Addr	atory 8/	(1) (<u>1</u>)	5000 50	Maryland	
ian ical		Martin D. La 23a. Per1. Enter the disease, or con- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death, yone cause on each limit	Do not enter the mode of dy	Road, Pa	Itimore, or respiratory are	Maryland est,	21212 Approximate Interval Between Onsevand Death	
	- 1	<i>M</i>	Due to (or as a conseque		semen	(4		Milyon	
9 6	CalEX	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. The to (or as a consequence. Due to (or as a consequence.) Due to (or as a consequence.)	nce of):	schen			Undynon	
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			1 - For State of Maryland / Dep Registrar Ce	artment of Heal	th and Mental Hy	giene 2005	28578
•	Physic /Med Exam	lical	Decedent's Name (First, Middle, Last) JOHN NORRIS RENNEBURG 4a. Facility Name (It not institution, give street and number)	4b. City, Town, or Loca	2. Date of De Month August	Day Year 29 2005	3. Time of Death 5:20 p M
Ky	Funera Directo		Greater Baltimore Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, $213-12-4193$ 1% $2\square F$ 93 Yrs. Usual Residence of Decedent	Towson If Under 1 Year If Under 1 Year Days Hou	nder 24 Hrs. 8. Date of Bir urs Min. January I	Baltimore th y, 1912 Baltimore 9. Bin Co Ma	e thplace (State or Foreign ountry) ryland
3	th the Maryland or 28a-f show	Director	10a. State 10b. County 10c. City, Town or Let Maryland Baltimore Luthervi 10e. Street and Number	11e		10g. Citizen of What Co	10d. Inside City Limits 1 Tyes 2 No puntry?
und	aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Innerkad other than "neturel" or items 23a or 28a-f show unatic event, the Medical Examinar must be notified at	by Funeral Director	1 □ Never Married 2 T Married 1 T TYPES 2 □ No W W		ic Origin? (Specify Yes or No ixican, Puerto Rican, etc.)	USA 14. Race - Ame Black, Whit Specify:	
	21215-0036 ed within 72 hours aft rgiene. ier than "neturel", or t, the Wedleal Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation be kind of work done during DO NOT use retired) , President	most of working	16b. Kind of Business	,
	Maryland 2: nd 2 should be filed v lith and Mental Hygie 27 is markad other t traumatic event, it.	To Be (17. Father's Name (First, Middle, Last) Frederick Philip Renneburg 19a. Informant's Name/Relationship (Type, Print) 19b. Maili		Mother's Name (First, Middle, Grace Louis umber or Rural Route Numbe	se Norris	Zip Code) 21003
	- 0		Ruth B Renneburg Wife 515 20a. Method of Disposition 20b. Place of Disposition cometery, cre-	Brightwood C	Club Road Luth	nerville, Ma 20c.Location-Cityor Baltimore,	aryland Town, State
:	Baltimore, permit. Pages 1 a Department of He- Important: If item any injury or othe		4	2. Name and Address of F	Facility Mitchell-Wie 600 York Road Bal	defeld Funeral timore, Maryla	. Home Inc.
•	Fnysician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hermanian Due to (or as a consequence disease): Sequentially list conditions.				Interval Between Onset and Death
	icate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		inch piece		
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	cords, P.O. w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in P	1 🗆 Y		obably 4 🗆 Unknown
<u>.</u>	VITAI HEC ilcien: The law certificate has rector, page 2 s	Be Completed	25. Was case referred to medical examiner?	26. F	24a. Was autop perfor 1 Yes	2 No 1 ☐ Yes	rtopsy findings available completion of cause of
	UNISION OT VITAI HECONGS, to Attending Physicien: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be of	ို	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatier 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatier 2 S8a. Date of Injury (Month, Day Year) 28b. Time of Injury			dence 6 Other (Spec	nfy)
Ċ	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	i Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) 29a. Certifier 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deatl		City or Tow	· · ·	
	To the Hos within 24 h To the Fur completely	Medicai	29b. Signature and title of certifier	vestigation, in my opinion, 29c. License numb	death occurred at the time, of	date and place, and due 29d. Date signed (Month	to the cause(s)
	16		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	347 R/1/201102	8/30/05	
		ate trar	30, Name and address of person who completed cause of death (Item 23a) (Type, CYU ftu a Sociano MD 670) N. C. 31. Date filed (Month, Day, Year) SEP 0 1 2005	edel	Sull belle	1-17 2120	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28579 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Judy A. Remley AUGUST 30, 2005 9:25P /Medical 4ć. County of Death Baltimore 4a Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City. Town, or Location of Death Examiner Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 5, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 20XF Virginia 56 Yrs 220-50-1379 Director 1948 W. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A XIX Yes 2 No Director Maryland Baltimore 5 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 428 Fawcett Street USA 21211 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2 Married 1 ☐ Yes XX No Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher St. Mary's Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oletta Riffle Joseph Cragneli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other treu Harry Remley 428 Fawcett Street 21211 Husband Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 9/3/05 Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Koad Baltimore, Maryland 21. Signature of Funeral Service Lidense Pint. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21211 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE ORGAN FAILURE DUE SIXWEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner TO SEPSIS SECONDARY TO LIVER METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner FROM COLO RECTAL RECTAL CANCER Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗀 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify)

The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760, physician the use as ŏ be detached the signed by has page 2 certificate or Attending Physician: this After

Pages 1 and 2 should be filed within 72 hours after death with the Maryland hent of Health and Mental Hygiene.

al Hygiene.

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at

worde

after death

completely filled in by the funeral To the Hospital of within 24 hours af To the Funeral D

Certification: To

Medical

State Registrar

PEMY CHHIM M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

1 🗌 Yes

27. Magmer of dath

1 Natural

3 Suicide

29a. Certifier

4 T Homicide

and manner stated

1 natient

te of Injury (Month, Day Year)

D26954

3□ DOA

28c. Injury at Work?

The certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 Yes 2 No

29d. Date signed (Month/ Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON, MARYLAND 21204

2005



2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend item 31 per dvr 8847
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year M une Kehak 2120 AM 08 27 05 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hopkins Medical Cente Baltimore N/AIf Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 79 Director Yrs. 214-20-7626 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Itams 23a or 28a-1 show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo Edgemere Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7308 Waldman Ave. 21219 filed within 72 hours after death by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give TYear or Dates: Specify: Specify 3 ☐ Widowed 4 ☐ Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Years Steel Industry traumatic event. 17. Father's Name (First, Middle, Last) rmit. Peges 1 and 2 should be fill partment of Health and Mental H portant: If them 27 Is marked ott y injury or other traumatic even Be 18. Mother's Name (First, Middle, Maiden Sumame) James M. McDonald Minnie C. Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7308 Waldman Ave. Mr. Louis Rehak (Husband) Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 9/1/2005 Baltimore, Maryland 21. Signature A Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PSis /Medical Due to (or as a consequence of): Examiner True Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last rinary Due to (or as a dinsequence of) Examine J physician and as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day Year 5 ☐ Other (specify) the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy perform certificate 1☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death After 1 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after control to the Funerel Director: Aft investigation 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.P. RES-000

DHMH 17 Rev 1/2001

State

Registrar

Bilti-ore

MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mayy Chahla 9819 Finsbury Rd, Bilti

2005

32. Registra Signature

31. Date filed (Month, Day, Year)

			For	State of Maryla	nd / Dep	artment of H	lealth and		giene	•
			1 - For State Registrar			rtificate of l		,	Reg. No.2 0 0 5	28581
	Physici	an	Decedent's Name (First, Middle, Land)	4 3				2. Date of De Month		3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, gi	errette		4b. City, Town, or	Location of Dan	Aug	29 00	
	Examir	ier			nter	01.	More	tn	4c. County of De	eath
	Funeral			Sex 7. Age (In yr	s. last birthday,	If Under 1 Year	If Under 24 Hrs		rth 9. B	irthplace (State or Foreign
	Director		220-20-9819	1 25 ₩ 2□F	7 / Yrs.	Months Days	Hours Min	MARCH	2,1928 1	PARYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	the Maryland 28a-f show	tor	MARVIAND A	1/4		BA	LTIMO	ORE (7, TV	1 AYes 2 □ No
	with the e or 28a Le noti	Direc	10e. Street and Number	1 6		10f. Zip Code			10g. Citizen of What	Country?
	= 23 ≡	Funeral Director	3401 KDA1		ENUE		2/2/	6	US.	
' 0	tter dea	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 12 Yes 2 □ No	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No to Rican, etc.)	5- 14. Race - An Black, Wi	nerican Indian, nite, etc.
5-0036	hours after turel', or Ite	by	3. Widowed 4 □ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	BLACK
	72 hours "neturel",	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wa	rking	16b. Kind of Busines	s/Industry
2121	within ene. then to M	Juno	Elementary/Secondary (0-12)	College (1-4or 5+)					Carrillian	OS GARAGE
	e filed I Hygi other ent, I	a)	17. Father's Name (First, Middle, Las	t)	1007	nuckuer			, Maiden Sumame)	DS GARAGE
Vlar	should be filed within of Mental Hygiene. marked other then maric event, the M	To B	SAMUEL T	THOMAS S	TERR	ETTE SR.	MAGO	31E	PAX	TON
Maryland	s 1 and 2 should be filed within 72 hours aft I Health and Mental Hygiene item 27 is marked other then "neturel", or other treumatic event, Ita Mudical Exam		19a. Informant's Name/Relationship	10	1	A			er, City or Town, State	
	is 1 and of Health item 27 other 1		CHERYL STEVENS 20a. Method of Disposition		Place of Dispo	Sosition (Name of		Date AVE	20c. Location - City of	K. MO. 21201
OT.	ages ent of nt: If it		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	☐Removal from State	cemetery, cre	matory or other plac TONALCE	·		17%	2
Baltimore	permit. Page Dep-rtment o Importent: If any injury or once.		21. Signature of Funeral Service Lice		D. NATE	2. Name and Addres	s of Facility	Bened	TE. FINI	ERAL HOME
œ.	Dep- Impo any is	- 11	(Dietuch	N. Willia	mo	2140 N.	FULTOI	AVE.	BALTO. A	10.21217
ш			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de y one cause on each line.	ath. Do not en	ter the mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Pnysician / /Medical		tmmediate Cause (Final disease or condition resulting in death)	a. Myocara	dial	Interche	~			Onset and Death
	Examiner			Due to (1) as a conse	equence of):	- 1				21.
		ner	Sequentially list conditions,	b. Due to (or as a cons.	adjuence of):	allon				200-42
6	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ances					2 montus
8760,	ate be execu nysician and he burial-tra	Ical E	rooding in dodiny cast	Due to (or as a conse	equence of);					
687	ate he he			d						
Вох	res that the death certifica igned by the attending pl be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregi		Ectopic pregnancy			23d. Date of d	elivery
О. В	e deal	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
۵.	that the ed by detacl	, Ph	Part II. Other significant conditions	contributing to death but not re	asulting in the u	inderlying cause give	an in Part I	23e. Did t	obacco use contribute	to the cause of death?
Records,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Completed by	Chronic obstra			disease	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Probably 4 Unknown
000	law requir as been si 2 should	olete	(1200021)	rera diseo	,			24a. Was		autopsy findings available
l Re	The lav ate has page 2 :	mo	Addied	lata -				autor perfo	prior to prmed? death?	completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					ath Check onl		
of	ding Physi T. After this o funeral dire	7.	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatier		4 Nursing F		dence 6 Other (Sp	ecify)
O	Attending it death. ector: Atterby the funer	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	al ?? ∕es 2 □ No	260. Describe	how injury occurred	
Division	Attendiu er death. ector: A by the fu	Certification:	3 Suicide 6 Could not to	De Con Blancot Inium. At	home, farm, str	reet, factory, office		28f. Location (Street and Number or F	Rural Route Number,
Ö	itel or irs afte rel Dira led in b	Cert						City or Tou		
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examin	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	ro the	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (Mon	ith, Day, Year)
	> 0		100	dm A		AULIA	64350	16747	8/29/00	
-	541		30. Name and address of person who		em 23a) (Type,	Print)			0 (0 (10)	3
	<i>y</i> .		Rishi R. Copts 31. Date filed (Month, Day, Year)	lag wes	ster 5	1. Balt	inore,	MD	21230	
	Sta Registr		SEP 0 1 20	33. Registrar's Sign	* Ans	وعظام				

Physicia	-47	Registrar 1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month AUGUST		3. Time of Death	
/Medic	al	Robert Lee Sho			45 Ob Tour	at and a st David			10:25P	
Examin	er	4a. Facility Name (If not institution, VA MARYLAND HEA				POINT		4c. County of Dea	ath	
Funeral		5. Social Security Number		7. Age (In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	h 9. Bi	rthplace (Stete or Forei	
Director		217-40-1786 Usual Residence of Decedent	1 ☑ M 2□F	62 Yrs.			Feb. 16	, 1943 Mar	yland	
WO	-	10a. State 10b. County		10c. City, Town or	-ocation				10d. Inside City Lim	
a-f sh uffled	ctor	MD Baltimo	re	Parkvill	e				1 □ Yes 🎞 🔀 I	
or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?	
18 23¢	erai	32 Dendron Crt.	12. Was Dece	dent Ever in U.S. 13	21234 . Was Decedent of F		pecify Yes or No-	USA 14. Race - Am	erican Indian.	
Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, Ite Madical Exam at most to a colling at	by Funeral Director	1 □ Never Married 2 → Marrie 3 □ Widowed 4 □ Divorced	Armed For	ces? 2 □ № 1966	If Yes, specify Cub 1 ☐ Yes 2 ☑ 💢 to	an, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc. white	
atural cat Ex	ted t	15. Decedent's	Education	1700	edent's Usual Occup e kind of work done	pation		16b. Kind of Business	s/Industry	
Mad Mad	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	life.	e kind of work done DO NOT use retire	during most of worl d)	king			
and Menial Hyglene. is marked other than sumatic event, If e Me	Con	12 17. Father's Name (First, Middle, L.		Manag	er	10. Mothada Nam		Hardware S Maiden Sumame)	tore	
ed of	Be	Leslie L. Show				Virginia		Malden Surname)		
mari mari	၉	19a. Informant's Name/Relationshi		19b. Ma	ling Address (Street			r, City or Town, State,	Zip Code)	
127 is er trau		Doris Showacre-	Wife	32 D	endron Cr	t. Parkvi	ille, Ma	ryland 212	34	
y or oth		20a. Method of Disposition 1								
Department of Health a Important: If item 27 is any injury or other traits once.		21. Signature of Funeral Service	4		22. Name and Addre	ess of Facility Lou	idon Par	k Funeral e, Marylan	Home	
2280	+	23a, Part1, Enter the disease, or o	omplications Make	aused the death. Do not e					Approximate	
ysician		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on e	ach line. LE RENAL FAI		-3,	, , , , , ,		Interval Between Onset and Death UNKNOWN	
ledical aminer		resulting in death)	115000-000	or as a consequence of):	10				UNKNOWN	
10	e	Sequentially list conditions, if any, leading to immediate	b	BETES MELLITO or as a consequence of):					OTALGRADAMA	
ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence of):						
S	ledical		u.							
attending properties for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live bi		□Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year	
the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐Unkno		Other (specify)				20,	
igned by the be detached		Part II. Other significant condition	s contributing to de	eath but not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	to the cause of death?	
been sign should be	ed by	CORONARY ARTERY	DISEASE				1 □ Y	es 2□No 3□P	robably 4 XUnkno	
as been 2 shoul	Completed	CEREBRAL VASCUI	AR DISEAS	SE			24a. Was a	sv prior to	utopsy findings availat completion of cause of	
page	Com						perfor	med? death? 2. No 1. Ye	s 2□No	
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea				
After this funeral dia	. To	1 Yes 2 X No 27. Manner of Death	الم	npatient 2 ER/Outpatient 1 ER/Outpatient 28b. Time Injury	of 28c. Injur	y at		ence 6 Other (Spe	ecify)	
the fund	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year) Injury		rk? Yes 2 □ No		now injury occurred		
Sire in by	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 289. Place	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow	treet and Number or Fi n, State)	lural Route Number,	
To the Funeral Direc completely filled in by	29a. Certifier (Check only (Ch									
o the	Mec	one) 29b. Signature and title of certifier	and manr	ier stateu.	29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)	
> - 0		1 Tom	illen	Pu	D30	272		AUGUST 29	9, 2005	
1	1	30. Name and address of person w	ho completed caus	e of death (Item 23a) (Type						
		THOMAS MILLER,	M D 352	MARIATE ANTO THE	TOTAL CARD	OTTOWN 1	DEPOST DO		01000	

NAME KNOWN TO PHYSICIAN: SHOWACRE, ROBERT L

State of Maryland / Department of Health and Mental Hygiene 2005 28583 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month .Physician 10:55 PM 30 Ruth C. Stump August 2005 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Owings Mills Baltimore Future Care Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Yrs. 18, 1914 213 01 4951 90 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show sunt be notified at 1 ☐ Yes 2 No Directo MD Carroll Finksburg 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 0 "naturel", or items 23a 1970 Deer Park Road 21048 United States Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Examiner: filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes ধ No Specify 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Cottege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, Ina. 2006. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Della Neal John Robey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Martin/Daughter 1970 Deer Park Road Finksburg, MD 21048 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9-2-2005 Ellicott City, MD * 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cem. 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Physician lon capitae /Medical Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 2 Yes 2 2 No 4 Pregnant at time of death 5 Other (specify) the. 0.0 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be leen 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause ol death? has autopsy performed? Yes 2⊠No 2 XNO 1 Yes 1 Yes funeral director. Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the c 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours a

To the Funeral C

completely filled i ro the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 125112 September 1, 2005

State Registrar

DHMH 17 Rev 1/2001

2005

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31. Date filed (Month, Day, Year)

1a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ourng8 Will

MD)

911

State of Maryland / Department of Health and Mental Hygiene 005 28584 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:30P M Belinda Maline Sadler August 2005 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges 5201 Morris Avenue #208 Suitland
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🗓 F 49 Yrs. Nov. 24, 1955 NC Director 242-04-6525 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examinational Language at 1 ☑ Yes 2 ☐ No Director P.G. Suitland Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5201 Morris Avenue #208 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "na any injury or other traumatic event, Ita Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Storeroom Supervisor Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mercida Mann Cleveland Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3014 Gainsville Street,
Washington, DC

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date SE #449B Tawana Sadler/daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 8/29/05 Clinton, Maryland 22. Name and Address of Facility Hodges & Edwards Fullet Hullet21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as ensequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a Was an certificate has 2**∑** No 1 Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 🗌 Yes death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n ABULHA SAW 31. Date filed (Month, Day, Year) ANSNA 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Decided Plane (First, Mode), Large Jessel B. Sailer As Facility Name (First and included property of the part of the par							Ce	rtifica	te of	Death		Reg. No. 20	0.5	28585
## Cauthy family Name (first vanishing, you are an an unusual) ## Renal space (First vanishing) was referred to medical form of the part		Physici	an								2. Date of Dea	ath	-	3. Time of Death
Renal searce Gardens Repair Service of Catoristy Number 5. Social Security Number 5. Social Securit	_									4h City Town or l				7:00 AM
Social Source Number Social Source Number Size Size	1	Examin	er							•		,		
The State of Department of Department of Department of Department (Catonsy) I 10c. Celly, Town or Location 10c. State of Was Carethy 10c. State of W						e (In vrs. I	ast hirthday)	If Und	er 1 Year					ce (State or Foreign
100. College of College of Catons VIII.e 100. To C				510-03-2850				Months	Days	Hours Min.	Aug 14	, 1917	Country Kansa	is
Jesse Bradbury	and	ŀ			10c. City	, Town or Lo	ocation					10d	l. Inside City Limits	
Jesse Bradbury	Many -fehr	호	Maryland Baltimo	re		Catons	svill	e					1 ☐ Yes 2 ☐ No	
Jesse Bradbury	r 28a	10e. Street and Number					10f. Zip Code					at Country	1?	
Jesse Bradbury	h with	aj D	709 Maiden Choice	Lane RGT	223			21228			U	SA		
Jesse Bradbury	ems ems	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?					Was Dec	edent of h	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race - Black,			
Jesse Bradbury 020	ours after el', or it Evando	by F.		1 ☐ Yes 2 🗖 N If Yes, Give Year or Dates:	No							Whit	e	
Jesse Bradbury 5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)		16a. Dece	dent's Us	Usual Occupation of work done during most of working			16b. Kind of Busi	ness/Indus	stry	
Jesse Bradbury 121	vithin ne. hen.	ğ			i+)			use retire	d)		Denartm	ent S	Store	
Jesse Bradbury 7	iled v Hygie her ti	ပိ	17 Fether's Name (First Middle Lest)	5+ buyer				18. Mother's Nam	ne (First Middle.			LOIE		
Physician / Medical Examiner Physician / Medical Examiner 23a. Part Lent the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate inferent Between Onset and Death Part Lent Le	ano	od of	Be	Jesse Bradbury										
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Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Medical Examiner Physician / Phy	ē,	s 1 ar f Hea tem 2						ame of	ca)		20c. Location - C	ity or Town	n, State	
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Physician Mediciae Examiner Page Physician Phys	_	40100		Thomas Gregor			2	299 F	rede	rick Roac	l Baltim	ore, Mary	yland	21228
OC STORY TO SEE THE PORT OF TH	1	/Medical Examiner	Jer	Immediate Cause /Final										nset and Death
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A SOLUTION OF THE PLAN OF THE	90	e exe cian a ouriel-	ũ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n.									
OC STORY TO SEE THE PORT OF TH	3876	cate b physic s the b	g	that initiated events resulting in death) Last	v	Due to (or	as a consec	uence of	:					
The control of the co		certifi ding se es		L	d									
The control of the co	ă	leath atter	iciai	Port II. Other eignifleent conditions co	atributing to dooth by	ut not recu	ulting in the u	nderlying	cause di	on in Part I	23h Did i	ohecco use contr	ibute to th	ne cause of death?
25. Was case referred to medical examiner? Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	Ö	t the c by the techer	hys	Constitutions co	tinbuting to death be	ut not resu	inting in the d	nderrying	cause gn	on my art i.			,	and the same of the same
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The control of the co		The la te has	E								101	res 2 No	1 □ Y	es 2 No
27. Manner of Death 1	ital									26. Place of Dea	th (Check only o	ne)		
The standard of the standard o	>	nysici nis ce I direc	10	P 1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA						4 Li Nursing n				
	פֿ	ng Ph ifter th unera		1 ☑Natural 5 ☐ Pending	28a. Dete of Inju (Month, Day	ry y Year)	28b. Time o Injury				28d. Describe h	now injury occurred	1	
	Sio	tendl feath tor: A	cati	3 ☐ Suicide 6 ☐ Could not be	Office Plans of Init	un. At ho	ma form at			Yes 2 INO	CONTINUE CON			Route Number
	Divi	or At after o Direct	3 Suicide 3 Suicide 4 Homicide 4 Homicide 4 Suicide 5 Suicide 4 Suicide 5 Suicide 4 Suicide 5 Suicide 6 Suicide 7 Suicide 6 Suicide 7 Suicide 8 Suicide 9 Suicide						ry, onice		City or Tox	vn, Stete)	or rigiai ri	loute (valinber,
		Hospital 24 hours Funerel tely filled	29a. Certifier (Check only one) Descripting Physicien: To the best of my knowledge, death occurred at the time, date of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, dependent of the description of the basis of exemination and/or investigation, in my opinion, description of the basis of exemination and/or investigation, in my opinion, description of the basis of exemination and/or investigation, in my opinion, description of the basis of exemination and/or investigation, in my opinion, description of the descr											
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n zigky		F ≯ F ŏ		No.					D 27989			31	SUCE	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		6		30. Name and address of person who c	ompleted cause of d	eath (Item	23a) (Type,	Print)	, 50	10 1	+	regue		
Mula M Character up 711 Maiden Choice La catorioville MD		13		N. 1 - NA O	HOT ME	5 7	11 M	Vai c	len	Choice	10 C	ivandto	lle	MD
State 31. Deteriled (Month, Day, Year) 32. Registrar's Signature SFP 0 1 2005		Sta	te ar	31. Date filed (Month, Day, Year)	•									

				partment of Health and N e <i>rtificate of Death</i>		iene 2005	28586
	Dhysis	-	1. Decedent's Name (First, Middle, Last)		2. Date of Dear	th	3. Time of Death
	Physici /Medi		MARGARET F. SPEAR		August	28, 2005	6:40 A ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			GLEN MEADOWS	Glen Arm		Baltimore	e County
в	Funeral Director		5. Social Security Number 6. Sex 1 M 2 7 F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			thplace (State or Foreign ountry)
			Usual Residence of Decedent		Dec 17,	_1904 Ma	ryland
	nyland how		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	e Ma	ctol	Maryland Baltimore County Glen A			1 ☐ Yes 2 ₹ No	
	or 28	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	ath w	rai	11630 Glen Arm Road	21057		USA	
	ltam Itam	une	Amed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show than "natural" or Itams 12a houlified at	by Funerai	1 XNever Married 2 Married 1 Yes 2 XNo If Yes, Give 1 Yes, Give 2 Year or Dates:	1 ☐ Yes 2 📆 No Specify:		Specify:	White
ŏ	2 hou	ted	15. Decedent's Education 16a, Dec	edent's Usual Occupation		16b. Kind of Business	
212	thin 7 9.	pie	(Specify only highest grade completed) (Given the complete of	re kind of work done during most of work . DO NOT use retired)	ing	Clothing	
	filed wil Hygien othar th ant, the	Completed		retary		Manufacti	ırer
lud	ba fill tal H d oth	Be		18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
돌	2 should ba and Mental is markad c	ç	John R. Spear	Lilli			
Maryland	permit. Pagas 1 and 2 should ba filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Modical Examinet must be notified at once.			iling Address (Street and Number or Run			
	1 and 1 Health am 27 Ithar tr		Mr. James W. Scharf (Nephew) 3145	Wheatfield Road,	Finksbur	S. MD 2104	8
no.	Pagas nent of thant: If its ant: If its		1 Nation 2 □ Cremation 3 □ Removal from State	ematory or other place)			
altimore,	artme ortan injury		`4 ☐Donation 5 ☐Other (Specify) 21. Signatu op i Funeyal Service Departue	Park Cemetery 8/31, 22. Name and Address of Facility	2005	Baltimore,	Maryland
B	permit. Departm Imports any inju			Mitchell-Wiedefeld	Funeral	Home, Inc	2.
	-		23a, Part1, Enter the disease, or complications that caused the death. Do not e	6500 Volt ing, su a ear i	li impre	Maryland	21212 ate
	Pnysician ·		shock, or heart failure. List only one cause on each line.	ome to b bo	202	0.	Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	C FRALTURA	100		10 days
	Examiner		DATHOL DAI	RF	EMUR	(O Choy	
	ם ב	Examiner	Sequentially list conditions. 1 any, leading to immediate cause. Enter Underlying				
V	ecute and trans	kam	that initiated events c.	PUSIS			10 ACHAI.
60,	cate be axecuted physician and s the burial-transit		Due to (or as a consequence of):				
68760	tificate be axecuted g physician and as the burial-transit	edicai	d				
ŏ	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	NAD!
ň	death e atte d for	icia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
0.0	tt the by the tache	hys	9 ☐ Unknown				
_	The law requires that the death cert are has been signed by the attendinage 2 should be detached for use	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord O	w requir been si should		JEME 10 1. 11		1 🗆 Yes	s 2 No 3 □ Pro	bably 4 Unknown
Records,	law r las be	Completed			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
		Con			perform		2/2No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
Ö	Phys this al dir	. To	1 ☐ Yes 2 ☐ Pro Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time			ice 6 Other (Spec	ify)
0	ding Phys h. After this funeral dir	tion	Matural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred	
Division	r Attandi er death. ractor: A by the fu	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm s		98f Location (Stre	eet and Number or Ru	ral Route Number
S	al or after	Certification:	4 Homicide determined building, etc. (Specify)	account according to the control of	City or Town,	State)	ar rioute Number,
	To tha Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ind due to the cau	use(s) and manner as	stated.	
	To tha Hos within 24 h To the Fur completely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month	Dey, Year)
		4	Romana gopalin !!	DS 1240		5/29/2	00)
	3		30. Name and eddress of person who completed cause of death (Item 23a) (Type LOCE COLD)	Pripe AM AN H GC	PHYAN	M	
	Sta	20	31. Date filed (Month, Day, Year) 32. Registrar's Signature	DAUIMORO	WU XI	228	
	Registra		SEP 0 1 2005 Beau & A	restil			
			OLI U I LOU ARREST				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 005 28587 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Year **Physician** Month AUGUST 28. 2005 5:45F /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Days Hours 1**X**M 2□F 38-60-4320 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Madical Examiner much be nuffled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 1 Yes 2 No Funeral Director nore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) other's Name (First, Middle, Maide Be Mailing Address (Street and 100 - Cife Town, State 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State ⁴ 4 □ Donation TECH MOUNT (1 21. Signature of Funeral Service Licensee 23a. Part1. Ther the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS DAYS /Medical Due to (or as a consequence of) **Examiner** HIV-INFECTION YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 21 No 2 No 1 Yes funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes Certification: To 2 X No 1 X Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending М investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Qay, Year) DØØ25886 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) MD 7671 OSLER DRIVE, TOWSON, MARYLAND 21204 State Registrar

			1 - For State Registrar			/ Depa		ealth and M Death	lental Hygi	•	
	Physici	an	1. Decedent's Name (First, Middle, Frederick		Jr				2. Date of Death Month	Day Yea	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, The Wesley Hom	give street and num	iber)	Ave.	4b. City, Town, or Baltimor	Location of Death	August 2	4c. County of De N/A	8:45 P.M
	Funeral Director		239-01-7715	6. Sex 1⊠M 2□F	7. Age (In yrs. last 90	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Aug. 5,	9. B 1915 Nor	irthplace (State or Foreign Country) th Carolina
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Balti	more	10c. City, To	own or Lo				10d. Inside City Limits 1 ☐ Yes XX No	
	th with the 23a or 28	al Director	10e. Street and Number 12212 Falls Roa	d			10f. Zip Code 2.	1030	100	j. Citízen of What (USA	
-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Heath and Mental Hygiene. ortent: if item 27 is marked other than "natural", or item 23a or 28a-f show injury or other traumatic event, Ite Modical Examination ust be matified at injury experience.	by Funeral	11. Marital Status 1 Never Married XX Marrie 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	9	ĺ	Vas Decedent of Hi fYes, specify Cuba I□Yes 2፟፟ÑNo	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
S PR	filed within 72 ho Hygiene. Ither than "natur ant, Iho M. Vicel	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed) College (1		(Give life. l	lent's Usual Occupi kind of work done o DO NOT use retired 1espersor	during most of worki)	ng 16	Sb. Kind of Busines General	•
Smith os C 84 Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, L Frederick		Sr.			18. Mother's Name		Peale	
2 .	and 2 should ealth and Men n 27 Is marke ier traumatic		19a. Informant's Name/Relationsh Rachel Smith	ip (Type, Print) Wife		1221	2 Falls	Road, Hun	t Valley,	Marylan	d 21030
Frederick Exp 8-28 Baltimore,	Pages 1 ment of He ent: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State Meti	ro Cr	sition (Name of natory or other plac ematory	8/30	/2005 (Catonsvil	le, MD
Ball Sal	permit, Page Department of Importent: If any injury or		21. Signatur of Funeral Service to	. Hens	s)						ng. 21211 nd
	Pnysician /Medical		23a. Part1. Enter the disease, or shock, of heart failure. List of immediate Cause (Final disease or condition resulting in death)	_aS	EPSIS		er the mode of dyin	g, such as cardiac c	r respiratory arres	t,	Approximate Interval Between Onset and Death ACU 75
	Examiner	er	Sequentially list conditions,	. RE	or as a consequent		BACT	JR EMIA	r		WEEKS
3760,	ate be execufed hysician and he burial-transif	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (d	CON/C or as a consequence	SP,	NAL	DISKIT	72		WEEKS
P.O. Box 68	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	1 Live bi	come of pregnancy rth 2 ∐Fetel dea ant at time of death wn	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	w requires that the d been signed by the should be detached	by	Part II. Other significant condition CHRONIC OBST		eath but not resulting PULMON	g in the ur	nderlying cause give	en in Part I.			to the cause of death? Probably 4 × Inknown
Reco	The taw re ate has bev page 2 sho	Completed	ANEMIA - C	NAL TA	Y ARTS	RY	DISEAS	Ē;	24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of
Vita	ician: certifica rector,	Be	25. Was case referred to medical examiner?	Hospital			Othe	26. Place of Death			
Division of Vital Records,	ding Physician: The lav th. : Atter this certificate has § funeral director, page 2.3	ıtlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig	28a. Date o	npatient 2 - ER/ f Injury h, Day Year)	Outpatien D. Time of Injury	28c. Injury Work	at Nursing Hor	ne 5∐ Residena 28d. Describe how	ce 6 □Other (Sp injury occurred	ecify)
Divisi	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place	of Injury - At home ig, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	he Hospik n 24 hours he Funere pletely fille	edical (29a. Certifier (Check only one) Certifying	Physician: To the xeminer: On the ba and mann	sis of examination	dge, death and/or inv	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
	To t withi To tl	W	29b. Signature and title of certifier	Pol	Jan D	3	29c. License	19425	290	. Date signed (Mon	nth, Day, Year)
	10		30. Name and address of person v	COMPleted carus	of death (Item 23	а) (Туре, <i>W</i> -	ROGERS	AVE-	BALTIM	OREM	D 2/209
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 1	- 1	egistrar's Signature	b	we			/	

		•	For State of Maryland / Dep	rtificate of Death	entai mygier Reg. N		28589
	D!!		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		John Henry Schnepf	·	August 2	7,2005	2:00 P M
4	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		tc. County of Death Baltimo	
-	Funeral		7909 St. Claire Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Dundalk If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		olece (State or Foreign ortry)
2.	Director		214-58-2569 ¹ ⊠M ² □F 55 Yrs.	Months Days Hours Min.	June 10,1	950 Mar	yland
	land Dw		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			0d. Inside City Limits
	Mary F sho	tor	Maryland Baltimore	Γ	oundalk 1 □ Yes 2 🖔 No		
	or 28c	Oirec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?		
	s 23e	ral	7909 St. Claire Lane 11 Marital Status 12. Was Decedent Ever in U.S. 13	21222		ited Stat	
(0	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is merked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marned 1 □ Ves 3 □ No If Yes, Give	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White,	
21215-0036	eral, o	þ	3 ☐ Widowed 4 🐒 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			White
15-	n 72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	ng 16b.	Kind of Business/In	dustry
212	y within	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	chanic		Machine	Operations
	al Hyg	BeC	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	_	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than " traumatic event, the Mac	2	John H. Schnepf, Sr.		Hazel C. I		Codol
Mai	id 2 sk Ith and 27 is n fraun			ing Address (Street and Number or Aura) 06 Delagrange Ave.			1205
ē,	itam		20a. Method of Disposition 20b. Place of Disposition	position (Name of Dematory or other place)	ate 20c.	Location - City or To	own, State
imo	Page ment g ent: If		ADonation 5 Other (Specify) Sacred H	t. of Jesus Cem. 9,	_	Dundalk,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If itam 27 is eny injury or other tra ance.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Duda-Ruck Funeral I 7922 Wise Ave. Dur	Home of Du	undalk, I	nc. 222
100			2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the property of heart failure. List only one cause on each line.			yrand 21	Approximate
	Physician			Cardiovascular		0	Interval Between Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):	- carerop ascarar	1 /- 2 - 3		y was
L	Examiner	P.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
4	uted d ansit	mln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
30,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	resulting in death) Last Due to (or as a consequence of):				
68760,	tificate be exe ig physician a as the burial-	dlca	d				
Box 6	n certif	-	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3			23d. Date of delive	ery
	e death cer he attendir ied for use	Completed by Physician/N	1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.0	v requires that the de been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	quires n sign	d by			1 🗆 Yes	2 □ No 3 □ Prot	oably 4 Munknown
000	aw rec is bee 2 shot	plete			24a. Was an autopsy		ppsy findings available impletion of cause of
R	The law cate has page 2:	Com			performed	? death?	2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death Other:			
of	y Phys er this eral di	n: To	1 No 2 No 10 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	ne 5 Residence 28d. Describe how in		y)
ion	Attending r death.	atio	1 Xatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St.		al Route Number,
	spitel ours a neral [29a. Certifier 1☐ Certifying Physicien: To the best of my knowledge, dea	ath occurred at the time, date and place, a	and due to the cause	(s) and manner as s	tated.
	he Ho in 24 h he Fui pletely	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date a	and place, and due t	o the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signature and title of certifler	29c. License number		Date signed (Month,	
		1	30. Name and address of person who completed cause of death (Item 23a) (Type	D18667	Hu	gust 29	7005
	7		Philip willialle M.D. 22 Courth Co.		, Marvlar	nd 21201	
	Sta		24 Date Stad (Month Day Your) 24 Pagistrat's Signature	ele			
	Regist	al	A T TOO WAS A STATE OF THE PARTY OF THE PART	Acres 100 Marie			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30,2005 8:08P M Sidlowski Jerome Michael August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 303 Raussell Place Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 XM 2□ F 60 Director Aug 5,1945 MD 214**-**44**-**3331 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Raussell Place 21146 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Trucking Supervisor Trucking Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aloyious Robert Sidlowski Elsie Goldenhorse ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Raussell Place Severna Park, MD.21146 Sandra L. Sidlowski (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sep 2, Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Brooklyn, MD. Signature of Funeral Service Licensee Name and Address of Facility Singleton Funeral Home Second Ave. S.W., Glen Burnie, MD 21061 ,0 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** inplastomo year /Medical Du (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' 2 No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 v Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 1 Inpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident Director: by the 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely (Check only one) Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35254 30. Name and address of person who completed cause of de th (I em 23a) (Type, Print) 901 ave BAYEMORO My 212 5 drole 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Month Year **Physician** 1:00 P M STANLEY 8 RAYMOND 29 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Arundel Pasadena 7688 Briar Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Director 82 12-22-1922 215-14-5472 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "neturel", or Items 23s or 28s-f show other traumatic event. The Medical Example requirements 1 ☐ Yes 2√∑ No MD Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7688 Briar Lane 21122 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Excavation Contractor Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be is marked o Dallas Stanley Eva Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna Stanley / Wife 7688 Briar Lane, Pasadena, MD 21122 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 2, Glen Burnie, MD 2005 Department of Importent: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Bernoval from State 4 □Donation 5 □ Other (Specify) Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Ave SW Glen Burnie MD 21061 M01411 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Pa 1. Enter ne de shock, or heart fail Immediate Cause (Final disease or condition resulting in death) Due to (or as a con equence of): monthe **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lissue of high y that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year jo 5 Other (specify) 4□Pregnant at time of death detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director examiner Other: 4 Nursing Home 5 residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28b. Time of Injury 27. Mann Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 46120

State Registrar 31. Date filed (Month, Day, Year) SFP 8 1 2015

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records.

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar 28592 Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 26, 2005 Robert Edward Sampson, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Apt. A 616 Harbourside Dr. Joppa If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7 / 15 / Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months Days Hours Connecticut **Director** 409-48-3014 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Joppa MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 USA 616 Harbourside Dr. Apt. A Itams 23a · death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. important: If item 27 is marked other than 'na any injury or other traumatic event, Ite Madic once. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Worker Construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2235 Eastern Ave. Baltimore, Md. 21224 Robert Sampson, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ZCremation 3 ☐ Removal from State Bayview Crematory 8/30/05 Baltimore, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kaczorowskifacii Funeral Home P.A. 2525 Fleet St. Baltimore, Md. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIABETES Physician MELLITUS, TYPE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner on Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Dav Year signed by the atte 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERTENSION 1 ☐ Yes 2 Probably 4 ☐ Unknown ER LIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s 2 4No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 ☐ Yes 2 ₺No Certification; To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier tercertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lew Nowalions & MI 30,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 125 N. MOLD ST. BEZALR mo ANDREW Now Akow Ski mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 1 2005 Registrar

			For State Registrar	State of Maryland		artment of Hetificate of L			Re	g. No.)5	
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	/Medic	al		BORSKI				A	ug !		1005	17.44
	Examin	Ç1	4a. Facility Name (If not institution, give si			4b. City, Town, or			7	4c. County	a/a	
			TOUNS HOPKINS BAY 5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 2		Date of Birth		-	lece (State or Foreign
	Funeral Director	1		M 25€F 88	Yrs.	Months Days	Hours	Min.	(Морір, Дау, .	Year)	Cour	yland
			Usual Residence of Decedent	00								
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	or 28	Oire	10e. Street and Number			10f. Zip Code			10	g. Citizen of W		ntry?
	23a	Funeral Director	620 S. Milton A				1224			USA		- 4 - 40 -
	er de	nue		 Was Decedent Ever in U.S. Armed Forces? 	13. \	Was Decedent of Hill f Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		. Amend k, White,	ean Indian, etc.
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Division of Vital Records,	Jing After fune	ion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work	γαι k? Yes 2 □ N		. 20301120 110	w injury occurr	00	
S	or Attending after death. Director: After in by the fune	lical	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon	ne, farm, str				Location (Str	eet and Numbe	er or Rura	J Route Number,
≦	after Direction by	Certification;	4 Homicide	building, etc. (Specify)		•			City or Town	State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		ician: To the best of my knowner: On the basis of examination and manner stated.								
	within 2 To the Complet	Me	29b. Signature and title of certifier			29c, License	e number		29	d. Date signed	(Month,	Day, Year)
)	F S F O		Destidant.	Onda 1	MIN	DEC	00	1		Luna	9 0	005
,	1		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,		00	,	, >	2	X	
)			AUSHA MANE			AUFINU	G (BALTI	MORE	MO:	42	24
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire		,			1		
	Regist	rar	SEP 0 1 2	205	K. I	mark)						
DH	MH 17 Rev 1/2	001	W -	James J	- 7							

			State of Maryland / Department of Health and M	lental Hyg	giene 2005	20501
			1- State Registrar amend item #8 per ana bd g8/9etijisaje of Peath 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	149. 140.	
н	Physicia /Medic		Andrew John Twist	Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number). 4b. City, Town, or Location of Death Cumber 1 5. Social Security Number 6. Sex 1. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.		4c. County of Dea	anu
	Funeral Director		526-52-6952 18 M 2□F 65 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day)	May	thplace (Sate or Foreign punity) LITE
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mary	ctor	MD Allegany Cumberland			1 ☐ Yes 2X No
	with the	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What C	ountry?
	ne 234	Funeral	516 Maryland Avenue 21502 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	acify Yas or No-	USA 14. Race - Am	erican Indian
920	2 should be filed within 72 hours after deeth with the Maryland and Memberd Hyglene. and Memberd Hyglene is marked other than "natural; or items 23s or 28s-f show aumatic event, the Medical Eval, and marked on tilliand at	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates: 158-88	Rican, etc.)	Black, Whi	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work.	ing	16b. Kind of Business	/Industry
12	within ene. than	jdwc	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (Navy	,	Military	
פ	e filed al Hygl other vent, I	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name			
ylaı	should b and Menta marked umatic e	To	Ralph Twist Leone Th			
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Cecilia Twist/spouse 516 Maryland Avenue Cu			
ē,	of Health item 27		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	
<u>E</u>	Pages ment of I ant: if its ury or of		'4 ⊠Donation 5 □ Other (Specify)			
Baltimore,	permit, Pages Depertment of Important: if it any injury or once.		21 Signature of Funeral Society Licensee Ronald S. Wart, Director State Anatomy Board Baltimore, MD 21201	d 655 W.	Baltimore	Street
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac card	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Dayse (Final disease or con ition resulting in death) a. Nutfive MyELosmor	41-1-1-1		71720
	Examiner		Due to (or as a consequence or).			
	p	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying			
	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physiclan and s the burial-transit	dicai E	d			
9	entifica ing phi e as th	Medi	IF FEMALE:			
Вох	eath certific attending p I for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date of de Month	livery Day Year
<u>о</u> .	thet the de led by the a detached f	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
	res the igned be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	bacco use contribute t	
ord	w require been sig should b	eted	Caronny Arrny DISTATE	1 U Y		robably 4 Unknown
Records,	a 2 5	Completed	WIAGERS MELLING TYPE 2	24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?			3 2 □ No
	유무등	은	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho		ence 6 Other (Spe	ecify)
on	Attending r death.	ation	27. Manner of Death Sala Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28a. Describe no	ow injury occurred	
Division of	or Atter efter dea Director	ertification;	3 Strigido 6 Could not be	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
_	To the Hospital or Attending Ph within 24 hours editor death. To the Funeral Director: Alier th completely filled in by the funeral	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the cred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the Within To the	Me	29b. Signature and title of certajer 29c. License number	2	9d. Date signed (Mon	th, Day, Year)
			Sun C. Sullins D42054	1.	JUGHIT 25	2005
			30. Name of address of person who impleted cause of death (Item 23a) (Type, Print)	bo do -	Juans 7 25 d MD 2	IEA2
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ver Ian	a mo	100d
	Registr		SEP 0 1 2005			

			1 - For State Registrar		State	of Mary	land / Dep <i>Ce</i>	artment of			lental Hygi	ene g. No. 20 (15	28595
			Decedent's Name (First	it, Middle, Las	st)						2. Date of Death	1		3. Time of Death
	Physici		Judith Ann	ne Trad	70						Month August	30, 200	ear 5	5:25 P.M
N.	/Medic Examir		4a. Facility Name (If not in			umber)		4b. City, Town	n, or Loca		Auguse	4c. County of		J.25 F.
	= 7.0.1111		Heritage (Center				Dunda.				Balti	more	2
	Funeral		5. Social Security Number		ex	7. Age (II	n yrs. last birthday	If Under 1 Ye	ar If L	Jnder 24 Hrs.	8. Date of Birth (Month, Day,			lace (State or Foreign try)
	Director		217-40-3129) 1	□ M 2 □ XF	62	Yrs.	Months Day	/s Ho	ours Min.	Apr. 14			vland
	P .		Usual Residence of Dece											
	arylar shov	_	10a. State 10b.	County		10	c. City, Town or L	ocation					10	Od. Inside City Limits
	89-f	cto		Baltim	ore		Roseda	le						1 ☐ Yes 2 📆No
	death with the Maryland me 23a or 28e-f show Frival be notified at	Director	10e. Street and Number					10f. Zip Cod	9		10	g. Citizen of Wh	at Coun	try?
	ath v		2 Breslin C	ourt,	Apt. 2			212				United		
	er de	Funerai	11. Marital Status		12. Was De Armed F	orces?	r in U.S. 13.	Was Decedent of If Yes, specify C	of Hispan uban, Me	nic Origin? (Spe exican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Black,	America White, e	
36	s afte	by F	1 ☐ Never Married 2 3 ☐ Widowed 4 🏋 🖸	_	If Yes, G	2 X No ive		1 ☐ Yes 2 ☒ N	io Sp	өсify:		Specify:		
21215-0036	hours after turel', or its				Year or	Dates:	100 Day	dent's Usual Oc						
Ċ	within 72 ene. then "nei	Completed	(Specify on		de completed		(Giv	kind of work do: DO NOT use ret	ne during	g most of worki	ng '	6b. Kind of Busi	ness/inc	iustry
7	the children	E o	Elementary/Secondary	(0-12)	College +4	(1-4or 5+)	Spec	ial Educ	- 	on Tood	20%	Cabaa	ī G	- t
	Hygid other	Be C	17. Father's Name (First,	Middle, Last)			, ppcc	IGI Dauc			(First, Middle, M	Schoo laiden Sumame)	L Sy	stem
<u>a</u>	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other then "natural", or iteme 23a or 28e-f ehow mailo event, the Maylical Expriment he notified at	ToB	Harley Cleo	n Powe	11				_	Tunna D	W-01-55			
Maryland	2 should and Men is marke	-	19a. Informant's Name/R				19b. Mail	ing Address (Stre			McShaff I Route Number,		ate, Zip	Code)
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		Douglas Tra	ce (So	n)		P. 0	Eox 63	.13	Daltim	re. Mar		220	
altimore,	tem item		20a. Method of Dispositio	n			20b. Place of Disp	osition (Name of matory or other)		I D	ate 2	c. Location - C	ty or To	wn, State
Ē	Pages nent of int: if it iry or o		1 □ Burial 2 ᡚ Gree 4 □ Donation 5 □ 0			State]	Hilltop :		*	9/1	/2005	Towson,	Mar	vland
<u>=</u>	permit. Pages Depertment of Important: if it eny injury or one		21. Signatur of uneral	Service Licen	see	1	0 2	2. Name and Ade	dress of	Facility	1/			
ñ	\$ 0 E 5 8		A sec	Jara	21	Cen		Ouda-Ruc	k Fu	neral E	Iome of I	Dundalk,	In	C.
			23a. Part1. Enter the disshock, or heart failu	ease, or com	plications that	caused the	death. Do not er	ter the mode of o	C AV lying, suc	renue I ch as cardiac o	r respiratory arre	- Marylar st,	id 2:	Approximate Interval Between
	Physician		Immediate Cause (Final	ile. Tonly	CA	PCI	MOM	9 A	F	111/	FR		10	Onset and Death
	/Medical		disease or condition resulting in death)		a. Due to	(or as a co	onsequence of):	1 \ \					2	- 100
п	Examiner		Convention by the constitution		Ь									
-		ner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury)	ns, ate	Due to	(or as a co	onsequence of):							
V	outer nd rans	Examine	that initiated events	•	c									
Š	e exe		resulting in death) Last	- 1	Due to	(or as a co	onsequence of):							
9/9	icete be executed physicien end s the burial-transit	dicai	d											
٥	e as	Mec	IF FEMALE:											
X Q Q	death certifi e attending i ed for use as	Physician/Me	23b. Was decedent pregr in the past 12 month			birth 2	Fetal death 3	⊒Ectopic pregna	ncy			23d. Date of Month		ry Day Year
	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4∐Preg 9∐Unki	nant at time nown	e of death 5	Other (specify)				WOIT	'	Day Feat
J.	res thet the de signed by the a be detached f	P	Part II. Other significant	conditions o	ontributing to	toath hut a	at consisting in the	andoch inn an inn		Dodl	22a Did taha			e cause of death?
Vital Records,	law requires thet the as been signed by th 2 should be detache	Completed by	DIARF	TF	C r	ME	LIT	1/5	given in	raiti.		/	□ Proba	
Ö	v require been si should t	etec	C0000	100	A	0 -	-E 0	1 711	=	100	-			
ě	The law cete has i page 2 s	idu	COPOR	YAK	-7	4	L	<u> </u>	71	1770	24a. Was an autopsy	b. We	re autop	sy findings available appletion of cause of
ᡖ	ilcian: The l certificete ha rector, page				/						autopsy perform † Yes 2	No 1	th? Yes :	2□ No
	Physician: rthis certific ral director,	Be	25. Was case referred to examiner?	medical	Hospital:			1,	26. Other: , ,	Place of Death	Check only one	1		
ō	Phys this ral di	<u>T</u>	1 Yes 250 No 27. Manner Death		28a. Date	Inpatient of Injury	2 ER/Outpatie	nt 3 DOA	4		ne 5 Residen		(Specify,)
0	ttending Phydeath. ctor: After thi the funeral	ţ	1 Matural 5	Pending investigation	(Moi	nth, Day Ye	nar) Injury	٧		2 □No	8d. Describe how	r injury occurred		
DIVISION	Nttendi death. ctor: A y the fu	lica		Could not be		e of Injury -	At home, farm, si				8f. Location (Stre	et and Number	or Bural	Pouta Number
2	after after Dire	Certification;	4 Homicide	determined	build	ling, etc. (S	Specify)	out, radiory, onle	~		City or Town,		01 710121	riodie ivamber,
	apita nours neral		29a. Certifier 1	Certifying Ph	ysician: To th	e best of m	y knowledge, dea	h occurred at the	time. da	ate and place. a	and due to the car	ISB(S) and mann	er as eta	ated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	(Check only 2 N	Aedical Exam	imer: On the i	pasis of exa oner stated.	amination and/or if	vestigation, in m	y opinion	n, death occurre	d at the time, dat	e and place, and	d due to	the cause(s)
	To the within To the To the Comp	M	29b. Signature and title of	certifier	OP			29c. Lice	nya nya	nber	290	d. Date signed (i	Month, D	Day, Year)
)			7100	20 40	Ju	- M	D		17/	416	UH	gust	31.	2005
	N		30. alme and audresis of	person whole	ompleted gau	se of death	(Item 23a) (Type	Prito Lil) - F	1 RI	TCHII	= 141	CL	INCAY -
	3		ULIVAI	.] -	3/14	, ,	112	PA	1	MAR	FIA	ARVIA	α	21225
	Sta		31. Date filed (Month, Da)	y. Year) P 0 1		Recustrar's	Signature	Rice R. D.	-11	1.101	-)11	11/41	1412	2123
	Registr	ar	5E											

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mildred Virginia Tressler 8:00 a. August 29, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel County Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 250 F Days Yrs **Director** 86 217-05-5651 February 18, 1919 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28e-1 shov the Medical Examiner must be notified at 1 Yes 2 No Directo Odenton Anne Arundei Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö U.S.A. Items 23a 21113 721 Pine Drift Dr Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Accounting Elementary/Secondary (0-12) College (1-4or 5+) Senior Cashier 2+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Health and Mental H lent: if itam 27 is marked other. Be Mildred Virginia Mollman 2 Rufus Thomas Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Importent: if itam 27 is
any injury or other treu 721 Pine Drift Dr. Odenton, Maryland 21113 Ms. Colleen P. Tressler Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 09/02/2005 Pfeiffers Corner, Maryland 20 nation 5 Other (Specify) Trinity Chapel Cemetery Signature of Juneral Service Licen 22. Name and Address of Facility Slack Funeral Home, P.A unterther 3871 Old Columbia Pike Ellicott City, MD 21043 ant. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sease or condition esulting in death) Pnysician KES Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumon 1 19 for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 21 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 No 1 Tyes 2 🗆 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of De Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending s after dec. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerei L To the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier Carkung Amajolis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in Wood 001 medi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1- For State of Maryland / Department of Health and M Certificate of Death	lental Hyg	giene 20	05 2859
	Physici /Medic Examir	al ·	1. Decedent's Name (First, Middle, Last) ARON ISAIAH VIAUD 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Dea Month AUGUST	th Day Yea	005 0703 AM
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 6 Yrs. 1 Months Days Hours Min. 1 Months Days Hours Min.	8. Date of Birth (Month, Day, July 11	Year)	Birthplace (State or Foreign Country) Maryland
_Q	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examment matural te notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 5245 Rising Sun Lane 21043 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Nev	ecify Yes or No-		,
d 21215-0036	filed within 72 hours after Hygiene. other than "natural", or ite ent, the Medical Exam	e Completed by	1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: No No Yes No No Yes No No No No No No No N	ng	Specify: 16b. Kind of Busine Educat: Maiden Sumame)	
Maryland	d 2 should be th and Mental t7 is marked o traumatic eve	To Be	Alain Viaud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	aud N Route Number	, City or Town, State	
Baltimore,	permit. Pages 1 and 2. Department of Health alimportant: if item 27 is any injury or other trau		20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Johns Cemetery 9-1-2 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry	2005 ry H. Wi	20c. Location - City Ellicott .tzke's Fa	city, MD mily FH Inc.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Enter			Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d		23d. Date of o	delivery Day Year
Records, P	w requires that been signed t should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sickle cell disease (Hemogloby 55)	23e. Did tob		to the cause of death? Probably 4 Unknown
Vital Rec		Se Completed	Done Marrow Transplantation Autoinmune Mepatitis 25. Was case referred to medical 26. Place of Death		prior t death	
Division of V	ding Phys n. After this funeral di	ation; To B	Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Nursing Home 2 Nursing Home Nursing Home 2 Nursing Home 2 Nursing Home	ne 5 Reside	nce 6 □Other (S _i w injury occurred	Decify)
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	al Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	City or Town	, State)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	29b. Signature and title of certifier 29c. License number	at the time, da	te and place, and d	ue to the cause(s)
	Ŋ		Mirole Shilliofsh no RES - 000 30. Name and address of person who comple cause of death (Item 23a) (Type, Print)			6 9002
	Sta Registr		SEP 0 1 2005 31. Date filed (Month, Day, Year) SEP 0 1 2005 32. Restar's Signature	MORE	MD 2	.1287

			1 - For State Ragistragmend item	State of Maryl	and / Depa	artment of H	lealth and N Reath	Mental Hyg	iene 20	05 28598
	1		Negistrating Name (First, Middle, Last	bto per ana	Da goarr	9701703	прави	2. Date of Deat	h	3. Time of Death
	Physicia							Month August 2	Day Ye	11:40 AM
	/Medic Examin		John Joseph Whee 4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County of D	
	LXdiffill	C1	1907 Jefferson F	Road		Dunda1k			Balti	more
12.0	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Yeer) 9.	Birthplace (State or Foreign Country)
	Director		217-54-3848	₹M 2□F 50	6 Yrs.	Months Days	Tiodis Will.	Feb 9,		laryland
	0		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	anting				10d. Inside City Limits
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_	Item Item	Ě	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☑ No	10.0	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		Vhite, etc.
2	al', or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2√√2No	Specify:		Specify: V	white
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	within 72 ene. than "nai	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	Amy		
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2	be filed within 72 hours after death with the Marylan Hydjene. Ad other than "natural", or liems 23a or 28a-f show event, the Modical Examples must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M		
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=	C/ c0 == 6		19a. Informant's Name/Relationship (**		ng Address <i>(Str</i> eet Jefferso			; City or Town, Stat ${ m MD} = 21222$	
	l and lealth im 27 ther to		Shirley Wheeler/s 20a. Method of Disposition		Db. Place of Dispo		on Road D		20c. Location - City	
0	Pages nert of thint: Int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other place	ce)		200. Location Only	or rown, outo
	t. Pa		' 4 ☑ Donation 5 ☐ Other (Specification)	/1		Name and Addra	on of English			
g	permit. Page Department of Important: If ony injury or once.		21. Signature of Funeral Service Licer Ronald S.	Wade, Direct					Baltimor	e Street
	141.55		23a. Part1. Anter the disease, or com	plications that caused the		altimore, er the mode of dvir			est.	Approximate
	#		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		DE-	2000			Interval Between Onset and Death
F	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cor	011 N)	Why X	est _			40 years
3,	Examiner			Due to (or as a cor	10 A	o RAMAS	245			24-54RAR
	概	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):	1 V VVV	V.			1 4 5 0
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
oʻ	an an rial-tr		resulting in death) Last	Due to (or as a cor	nsequence of):					
8760	death certificate be executed e attending physician and id for use as the burial-transit	dicai	•	d						
9	ng pt ng pt	Med	IF FEMALE:							
Box	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of printing 1 Live birth 2	Fetal death 3	Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
o.	e des the al	Physician/Me	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				
<u>م</u>	res that the de signed by the a be detached t		Part II. Other significant conditions of	contributing to death but no	t resulting in the u	nderlying cause giv	en in Part I	23e. Did tot	pacco use contribut	te to the cause of death?
ŝ	The law requires that the te has been signed by th vage 2 should be detache	i by	Takin. Othor signmount contained	contributing to document no	troducing in the s	ildonying occord give		1 □ Ye	es 2500 3	Probably 4 Unknown
0.0	w require been si should l	Completed						24a. Was a	a 24h War	a cuta par findings available
ec ec	: The law cate has l , page 2 s	mp						autops	y prior deat	e autopsy findings available to completion of cause of h?
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=	ysician: ais certifica director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3□ DOA Oth		th (Check only on	e) ence 6 ⊡Other(Canaity)
o	Phy or this oral d	To To	27. Manner of Death	28a. Date of Injury (Month, Day Yee					ow injury occurred	эрвспу
0	nding P tth. :: After	atlo	Datural 5 Pending 2 Accident investigation		er) Injury		Yes 2 □ No			
N N	Atte	ifice	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, str	reet, factory, office		28f. Location (St City or Town		r Rural Route Number,
	s afte el Dir ed in	Certification:		Building, etc. (5)						
	ne Hospitel or Attending Physicien: Ti Az hours atter death. Ne Eunerel Director: Affer this certificate bletely filled in by the funeral director, pa		29a. Certifier Certifying Pt	nysicien: To the best of my miner: On the basis of exa-	knowledge, deat	h occurred at the tir	me, date and place	, and due to the ca	ause(s) and manne	r as stated. due to the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	ledical	one)	and manner stated.	Thirties and a second					
	To the within To the	Σ	29b. Signature and title of certifier	1/1		29c. Licens	PO TO CO	2	9d. Date signed (M	romn, Day, Year)
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			30. Name and address of person who	completed cause of death	(Item 23a) (Type)	Print)	015	7 308	BULL	40 AD 7037
	- 01-		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	avery min	Ry N	11/00	V/WY	WK /MY U/U//
Jay.	Sta Registi		050	2005	H A	made 8				

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Way 29 2226 2005 ne ChinqusT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner toward Howard County burn Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑** M 2□ F Yrs. Jan 3, 1943 62 Director 214 40 8573 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or items 23s or 28s-f show the Medical Example roust be notified at 1 ☐ Yes 2 ☑ No Director MD Ellicott City Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3472 Orange Grove Court 21043 United States death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. ð Spacify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications h and Mental Hygier 7 is marked other th Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roy Thomas Wright Anna Louise Dulin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i Theresa L. Wright/Wife 3472 Orange Grove Court Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of P
Important: If its
any injury or ot 1 ☐ Burial 2 X remation 3 ☐ Removal from State Metro Crematory 9-2-2005 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final CARDINASULV & 1) EATE **Physician** disease or condition resulting in death) AMenscienha /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 🗌 Yes 2 No as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has раде 20 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: the 6 Could not be determined within 24 hours after der To the Funerel Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title pf certifier 29c. License number 29d. Date signed (Month, Day, Year) En Alledon 0 who completed cause of death (Item 23a) (Type Print) HOWALD - MOSSIS 5755 31. Date filed (Month, Day, Year) 32. Strar's Signature State SEP 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0 Day Year Month **Physician** 4:10PM WILT CHLENDINE 18 2005 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Bon Secours Hospital Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adapthe Dave Hours Min. (Month, Day, Year) 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 210 F Yrs. Director 62 1943 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked othar than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Md. Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4928 Brookwood Road 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked othar than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Retail Food Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Wilt Pauline Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun <u>once.</u> 4928 Brookwood Road, Baltimore, Maryland 21225 Sandra L. Burke / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1

Burial 2 □ Cremation 3 □ Removal from State enation 5 Other (Specify) Loudon Park Cemetery 8/23/2005 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. e of Funeral Service Licensee 21. Signatu 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician RIGHT LUNG PNUEMONIA DAYS /Medical Examiner OF CARCINONA LOLON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1ALN 以TR,T10N 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No A) 36 6 30 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 23300 August 18 2005 BON SELVIRS HUSP, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL, SUDHIR, BALTO, ST. BALTO MD. 21223 2000W, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 1 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of F tificate of	lealth and N Death	nental Hygiene Reg. No		28601
I	Physici	an	1. Decedent's Name (First, Middle, Last) CHARLENE		WR	CIGHT		2. Date of Death Month Da	*	3. Time of Death
-	/Medic Examin		4a. Facility Name (If not institution, give s		,	4b. City, Town, o	r Location of Death	CITY 40	7 2005 County of Death	0.5117
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la	,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year, 9/25/19	Cour	place (State or Foreign htty) USA
	anyland show	L	10a. State 10b. County		Town or Lo				1	0d. Inside City Limits
	the Ma 28a-f	Director	10e. Street and Number		BAITI	MORE 10f. Zip Code		10g Ci	tizen of What Cour	1. Yes 2 No
	h with	al Di	232 NORTH BE	20ADUIAA		Tot. Zip dode		109. 01	1154	my:
36	parmit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural", or Itams 23a or 28a-f show miportant: If team 27 is marked other than "actival Examinar must be rediffed at once. any injury or other traumatic avent, the Medical Examinar must be rediffed at once.	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036	"natura	Completed	15. Decedent's Educ (Specify only highest grade	ation	(Give	tent's Usual Occup kind of work done DO NOT use retire	during most of work	sing 16b. H	(ind of Business/In	dustry
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Ba	parmit. Departn Imports any inju		21. Signature of uneral strice Licens	Illan	22			HELS METRO		
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	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in	edical	29a. Certifier (Check only one)	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or in	n occurred at the til vestigation, in my o	me, date and place, pinion, death occur	and due to the cause(s red at the time, date an) and manner as si d place, and due to	tated. the cause(s)
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			30. Name and address of person who co	CHICAGO TITL UN	23a) (Type,	Print) 600	North	Street P	hip 5	Baltimore
:	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signation	IF A	orde	40-110	٥,٠٠٠/	901	11/ 6/60/

August County of Death C		an	1	Decedent's Name	e (Fifst, Midd		ILLAN	I DOI			/11 1 1	ANG			2. Date of D Month	eath Da	ay	Year	3. Time o	of Death
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17. Father's Name (First, Microse, Surrey and Number's Plant Routines Surrey) 19a. Informant's Name (First, Microse, Surrey) 19b. Mailing Address (Sireal and Number's Plant Routines) 19a. Informant's Name (First, Microse, Surrey) 19b. Mailing Address (Sireal and Number's Plant Routines) 19a. Informant's Name (First, Microse, Surrey) 19b. Mailing Address (Sireal and Number's Plant Routines) 19b. Mailing Addr	al', or its Exemina	þ					1 ☐ Yes If Yes, Giv	2 No	14						Hican, etc.)					
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192 Informant's Name/Relationship (Type, Prof) 193 Informant's Name/Relationship (Type, Prof) 194 Informant's Name/Relationship (Type, Prof) 195 Informant's Name/Relationship (Type, Prof) 195 Informant's Name/Relationship (Type, Prof) 196 Informant's Name/Relationship (Type, Prof) 197 Information 198 Informant's Name/Relationship (Type, Prof) 199 Informant's Name/Relationship (Type, Prof) 199 Informant's Name/Relationship (Type, Prof) 199 Informant's Name/Relationship (Type, Prof) 190 Informant's Name/Relationship (Type, Prof) 190 Informant's Name/Relationship (Type, Prof) 199 Informant's Name/Relationship (Type, Prof) 190 Informationship (Type, Prof)	Hygien	Соп	_		NA	, Last)				N	14		18. Moth	er's Name	e (First. Middle	Naider	ff n Sumam	ne)		
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Committee Comm	₹2±		TIFFANY WILLIAMS Mother 2308 E. NORTH AVE. E																	
Millier's Metropolitan Chapel P.C. 1639 North Broadway Baltimore Maryland 21213	Pages Iment or tant: If jury or	20a	1 Burial /2	Cremation	3 □Rem	noval from S		cemet	ery, crem	natory or o	other place		8	Date/ 1/2/25	20c. L		•			
Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 238/Part I. Entry Indicases of complications what caused the death. Dornot enter the mode of dying, such as cardiac or respiratory arrest. Approximate inference Developed Standard Course (Final Legislator) and Death in Infancy	Departm Importa eny inju once.		21	Signature of Jur	nervi Service	Linsee	ller			22.	I.	Viller"s	Metro	oolitan	Chapel P	.C.	andana	4 2424	9	
FFMALE: 23b. Was decedent pregnant in the past 12 months? 1	/Medical Examiner		100	1 Burial Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signalus of uneral Service Lissee 22. Name and Address of Facil Miller's Metro 1639 North Bi 23a Part 1. Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. 23 Sudden Unexplained Death in Inferesulting in death) 24 Donation 5 Other (Specify) 25 Name and Address of Facil Miller's Metro 1639 North Bi 1639 Sudden Unexplained Death in Inferesulting in death)							ancv					Oriset and				
24a. Was an autopsy findings availar prior to completion of cause of death? 25. Was case referred to medical examiner? 127	ician and burial-transit		Serif a cau	quentially list con ny, leading to im- ise. Enter Under use (Disease or i t initiated events	nditions, mediate rtying injury	a b c d	Due to (d	or as a cor	nsequence	e of): e of):	Dea	th in	n Inf	ancy					Onset and	
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25. Was case referred to medical examiner? 1	igned by the attending physician and be delached for use as the burial-transit	by Physician/Medical	Serif as cau cau that res	quentially list con ry, leading to im. ise. Enter Under use (Disease or it initiated events ulting in death) L FEMALE: . Was decedent in the past 12 r 1	pregnant months?	b c d 23c.	Due to (d) Due to (d) Due to (d) If yes, outd 1 Live bi 4 Pregna 9 Unkno	or as a cor	nsequence nsequence regnancy Fetal death	e of): e of): e of): 5 □	lEctopic p	regnancy				tobacco	Mor	nth ribute to th	Day Day	Year
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	n. After this certificete has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Serif and cau Cau Cau that res	quentially list con my, leading to im se. Enter Under use (Disease or it initiated events ulting in death) L -EMALE: . Was decedent in the past 12 in the	pregnant months? No icant conditions	d	Due to (compute to	or as a cor or as a cor or as a cor or as a cor come of pr rith 2 □ ant at time win ath but not ath but not finjury h, Day Yea	nsequence nsequence regnancy Fetal death of death of resulting	e of): e of): e of): th 3	Ectopic pi Other (sp inderlying c	oregnancy pecify) cause give	n in Part I	e of Death	24a. Was auto performe 5 Resi	Yes 2 an psy pormed? 2 □ No one)	Moruse contr	nth iribute to th iribute to confidence iribute to confi	Day Day De cause of cably 4 (2) psy findings neletion of cable 2 \(\text{No} \)	Death Year Unknow availab ause of
1110	n. After this certificete has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Serif and cau Cau Cau that res	quentially list con ny, leading to impose. Enter Under use (Disease or it initiated events ulting in death) L FEMALE: D. Was decedent in the past 12 if 1 Yes 2 yes 2 yes under und under und under und under un	pregnant months? No cant conditions investifications S Pendia	d	Due to (d) Due to (d) Due to (d) If yes, outcome to (d) Pregna 9 Unkno buting to de pital: 1	or as a cor ant at time with 2 □ ant at time with 1 injury b, Day Yea 15 of Injury Yea 15	regnancy Fetal death of death of resulting	e of): e of): e of): th 3	Dectopic piglical Dectoration of the control of the	cause give	n in Part I	e of Death	24a. Was auto perfc 128 yes a (Check only of the check only of the	Yes 2 an psy primed? 2 No one) dence how injuit	Moruse control No 24b. V P d 1 6 □Otherry occurred	ribute to the street of the st	Day Day De cause of cably 4 120 psy findings inpletion of cable 2 No	Year death? Unknow available ause of
0.C.M.E. August 09, 2005	n. After this certificete has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Serif a cau cau cau cau cau res	quentially list con ny, leading to im use. Enter Under use (Disease or it initiated events ulting in death) L	pregnant months? No icant condition Figure 1 Pendia investi Could determ	d	Due to (compute to	or as a cor or as	nsequence nsequence nsequence regnancy Fetal death of death of death at resulting 2 DER/O 28b. Fo 28b. Fo 2cify)	e of): e of): e of): th 3	DEctopic pi	cause give	26. Place 26. Place 17. 4 \(\) Nu at 27. Yes 2 \(\) X	e of Death	24a. Was auto perfect 102/Yes on (Check only of City or To Baltimo	Yes 2 an psy ormed? 2 No one) dence how injuite the win, State Dre, cause(s)	Mor use control No 24b. V p d 1 6 □Otherry occurred Md and mean	nith iribute to the strict of	psy findings poletion of co	Year death? Unknown available ause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n. After this certificete has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	See if a a cai cai cai tha res	quentially list con ny, leading to im lise. Enter Under use (Disease or it initiated events ulting in death) L FEMALE: D. Was decedent in the past 12 in 1 Yes 2	pregnant months? No cant conditions mediate trying injury ast	d. 23c.	Due to (compute to	or as a cor or as	nsequence nsequence nsequence regnancy Fetal death of death of death at resulting 2 DER/O 28b. Fo 28b. Fo 2cify)	e of): e of): e of): th 3	DEctopic pic of Other (sp. other sp. other) of A M Dect. factor	cause give	26. Place T. 4 Nu at ? fes 2	e of Death	24a. Was auto perfect 102/Yes on (Check only of City or To Baltimo	Yes 2 an psy prmed? 2 □ No one) dence how injuit Street and one, State DIC , cause(s) date and	Moruse control No 24b. V d O 1 6 Other ry occurre Md Md Md	note to the state of the state	psy findings poletion of control	Year death? Unknown available ause of

			for State Registrar	State of M	Maryland / Depa Ce	artment of H			ene	28603
			1. Decedent's Name (First, Middle, La	st)		-		2. Date of Death		3. Time of Death
	Physici /Medio		MILDRED KOET	TER WOLF				August	31, 2005	9:30 A ^M
	Examir		4a. Facility Name (If not institution, giv		er)		Location of Death		4c. County of De	
			OAK CREST VILLAC		Age (In yrs. last birthday)	Parkvil	le If Under 24 Hrs.	8 Date of Birth		ce County
	Funeral Director			□M 21 F	90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
			Usual Residence of Decedent					July 3,	191) MI.	ssouri
	ahow	_	10a. State 10b. County	_	10c. City, Town or Lo					10d. Inside City Limits
	Ba-f	Director	Maryland Baltimor	e County	Park	ville			>= Chi======6.04/b==4	1 □ Yes 2√ No
	a or 2	Ö		1		10f. Zip Code	00/	10	g. Citizen of What	Country?
	ns 23	era	8834 Walther Blv	12. Was Decede	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	.234 spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ar	merican Indian,
9	or iter	by Funeral	1 ☐ Never Married 2 ☑ Married	Armed Force 1 Yes 21 If Yes, Give	s? Z No	If Yes, specify Cubai 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, W	hite, etc.
03	72 hours after death with the Maryland Inctural', or Items 23s or 28s-f show Jissi Examiner must be notified at	dby	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:	1 Yes 2LANO	Specify:		Specify:	White
21215-0036	"netu	Completed	15. Decedent's E (Specify only highest gr		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired,	ation furing most of work	ing	6b. Kind of Busines	ss/Industry
12	within ene. than "	d L	Elementary/Secondary (0-12)	College (1-4d	or 5+)	emaker	,		Own Resi	danas
	filed Hygid other ent, I	Be Co	17. Father's Name (First, Middle, Last)	ПОШЕ	maker	18. Mother's Name	e (First, Middle, N		dence
lan	fental fental rked c	To B	Gustav		Koetter		Pauline	Kio	ssling	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23s or 28s-f show other trauments event, the Medical Evantise must be notified as		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a				, Zip Code)
	and 2 ealth m 27		Mrs. Janet R. Hol 20a. Method of Disposition 1 Burial 2 Tour Email on 3 F	borow (Da	aughter) 376	88 Albatro	ss Stree	t, San D	iego, CA	92103
ore	Pages 1 nent of H. ent: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	te 20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	9)	Date 2	t0c. Location - City	or Town, State
Baltimore,	tmen tent:		`4 □Donation 5 □ Other (Special	(y)	Green Mo	unt Crema	tory 9/	3/2005	Baltimore	e, Maryland
Ba	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu		21. Signature // uneral ervice Lize	FTTON	_ N	2. Name and Addres Litchell-V	Viedefeld			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death. Do not en	ter the mode of dying	g, such as cardiac	ttimore, or respiratory arre	Mary Land	Interval Between
	Physician		Immediate Cause (Final disease or condition	AS	CVIO					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					11.0.11.0
	Examiner		Sequentially list conditions,	b	as a consequence of):					
J	led nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence or):					
v ·	be executed lician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	as a consequence of):					
8760,	icate be ex physician s the buria	dical E	(d						
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	fedi								
Вох	death certifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth		Ectopic pregnancy			23d. Date of o	lelivery Day Year
	ne dea the at thed fo	Physician/Me	1 Yes 2 No	4□Pregnant 9□Unknowr	at time of death 5	Other (specify)			MORE	Day real
P.0	that the de ed by the detached		Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause give	on in Part I.	23e. Did tob	acco use contribute	to the cause of death?
of Vital Records,	uires tha signed Id be det	Completed by	Hy R Hy (o.	Sum	Adrena	INCH	Micron	1 ☐ Ye	s 2 No 3	Probably 4 Unknown
CO	w require been si should b	lete						24a. Was an	24b. Were	autopsy findings available
Re	The la te has age 2	omp						autopsy perform	edz prior to	o completion of cause of
ital	ian: rtifica stor, p	Be C	25. Was case referred to medical				26. Place of Deat	- 4		2 2 2 10
>	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 ER/Outpatie	nt 3□ DOA Othe	r: 4 Nursing Ho	me 5 ☐ Resider	nce 6 Other (Sp	pecify)
п	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of l (Month,	njury 28b. Time o Day Year) Injury	Work		28d. Describe how	w injury occurred	
Sio	tendi leath. tor: A the fu	cat	2 Accident investigatio				/es 2 □No	204		
Division	l or At after of Direc	Certification:	4 Homicide determined	280. PJ200 01	Injury - At home, farm, st etc. (Specify)	reet, factory, office		City or Town,	ser and Number or : State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	(Check only 2 Medical Example 12 Medical Example 2 Medical Example	niner: On the basis	st of my knowledge, deat s of examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	o the ithin 2 o the mplet	Med	one) 29b. Signature and title of certifier	and manner	SIATOC.	29c, License	number	29	d. Date signed (Mo.	nth, Day, Year)
•	⊢ ≱ ⊢ 8) /1	1		OF	3(10	1	J L	31 2001
	~		30. Name and address of person who	completed cause of	of death (Item 23a) (Type.	Print)	× 1 11		NINT	01 200
	8		Jeff Landi	mu	8800 1	wo lthe	15/2	Pa	kull 1	NO 21234
	Sta	1.0	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	16.0				
	Registi	rar	SEP 0 1 2005	Berlin	15 19700					

Muchuel K. Wolf

State of Maryland / Department of Health and Mental Hygiene For State Registrar 28604 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 17:30 M GEORGE WILSON 2005 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**∑**M 2□F Director 6, 1919 Virginia 216-14-3935 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö Items 23a 3103 River Drive Road United_States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1X()Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WW II 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter-Bethlehem Steel 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eliza Woodson George Wilson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3103 River Drive Road Ed emere, Maryland 21219 Ellie P. Wilson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Important: If any injury or once. 4 □ Donation 5 ☑ Other (Specify) Entombment Holly Hill Cemetery 9/2/2005 Middle River, Maryland 21. Signal re Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 DAYS STROKE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by CONGESTIVE MEART FAILURE 2 No 3 Probably 4 Unknown 1 Tes HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) Gardh MD, MPH AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR NISHIENA GANDHI, JOHNS HOPKING BMC, 4940 EASTERN AVE, BALTIMORE MD 21224 13 Registrar's Signature 1 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2005 28605 For State Registreamend item #10e per ana bd g84/rificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST **Physician** 1843M LORENCE 2005 WILSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TMORE
If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Min Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, It a Madical Examinar mans 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No HIMORE MO Director 10g. Citizen of What Country? 10f. Zip Code 404 10e. Street and Number USA Conway Street - WES Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No MICHOTAI 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 communications telephone operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Rose Wheeler Josias Louis Wilson 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20628 Mary Ann Clark/sister Box 150 Daneron, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐Other (Specify) 21. S nature of Funeral Sep ice Licensee Ronald S. W. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY **Physician** /Medical Due to (or as RANSFUSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner RHEUMATOID ARTHRITIS burial-transit ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent premant in the past 12 menths?
1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month 4 Pregnant at time of death 5 Other (specify) Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown ARTERY 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) L □ noatient 3 DOA 2 ER/Outpatient 1 🗌 Yes Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 27. Manner Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature P14408 o completed cause of death (Item 23a) (Type, Print) 22 South GREENE STREET 3

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 1 2005

Coase

Registrar's Signature

BALTIMORE, MD

7 21016	ın	1. Decedent's Name (First, Middle, La Elmer Richard Yannus:		Dishand	Vormunai		Date of Death Month UGUST 30,	^{Day} 2005	3. Time of Death
<i>l</i> ledic	al -	4a. Facility Name (If not institution, giv		Richard	Yannuzzi 4b. City, Town, or Loca		agase so,	4c. County of	
amin	S1	Good Samritan Nursing			Baltimore			N/A	
eral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year If U		Date of Birth (Month, Day, Y		Birthplace (State or Fore Country)
ctor		216-01-7566	1 X M 2 □ F	94 Yrs.	Months Days Ho				ennsylvania
700	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim
ladical Examinational bancified at	ō			Baltimore					1 [X] Yes 2 □
THC.	Directo	Maryland N/A 10e. Street and Number		Datellibre	10f. Zip Code		10g	. Citizen of Wha	at Country?
3		1651 Belvedere Avenue	2		21239			U.S.A.	
E G	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specif	y Yes or No-	14. Race -	American Indian, White, etc.
割		1 ☐ Never Married 2 ☐ Married	1 Tes 2 N		V	oecify:	, 0.0.,	Specify:	TTIMO, OLO.
Exa	d by	3 X Widowed 4 □ Divorced	Year or Dates:					V	<u>White</u>
dica	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	g most of working	10	b. Kind of Busir	ness/industry
M aci	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+) Uphols			(-	eneral Mo	ntors
ant, I	e C	17. Father's Name (First, Middle, Last	")	Торпота		Mother's Name (F			7001 3
ic ev	To B	Carmen Yannuzzi			R	Rose Bronz	e		
other treumatic	-	19a. Informant's Name/Relationship	(Type, Print)		ing Address (Street and t				
er tre		Teresa R. Brocato -	Daughter	1729	Wadsworth Way	/ Baltim	ore, Mary	land 2123	39
othe		20a. Method of Disposition	Demoual from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date	9 20	c. Location - Ci	ty or Town, State
ıry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Co		New Cathe	dral Cemetery	9/01/20	05 E	altimore,	Maryland
any injury o once.		21. Signature of Frontal Salvio	Charles F	. Miner 2	2. Name and Address of	Facility Leonar	d J. Ruck	, Inc.	24.4
E 8		Elwy 111	lner		5305 Harford r			-	
		23a. Part1. Enter the disease, or con shock, or heart alure. List only	nplications that caused one cause on ea	the death. Do not en	nter the mode of dying, su	uch as cardiac or re	espiratory arres	t,	Approximate Interval Betweer Onset and Deatl
cian	14	Immediate Cause (Final disease or condition		ehndi	alion				0.000, 4.00
lical iner		resulting in death)	Due to (or as	a consequence of):	0-				
mei	L	Sequentially list conditions,	b. Due to for as	a consequence of):	ug				
sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter U conjung Cause (Disease or injury	D00 to (01 d3	a consequence on.					
al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					=
s the burial-transit			d						
as the	edical		0.					_	
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death 3	☐Ectopic pregnancy			23d. Date	
detached for use	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at		Other (specify)			Month	n Day Year
ache	Physician/M	9 Unknown	9□ Unknown						
-	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause given in	r Part I.			ute to the cause of death Probably 4 Unknown
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, O	Completed	Ceret	roves	cular	accid	ent	24a. Was an autopsy	prid	ere autopsy findings avail or to completion of cause
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al director, page 2 should be	To Be	1 ☐ Yes 2 No	Hospital: 1 Inpatie		of 28c Injury at		a. D		
al director, page 2 should be	To Be	1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending	28a. Date of Inju	ry 28b. Time	Work?	2 □No			
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2005

AUGUST 29.

			For State Registrer	State of Maryla		artment of H			giene Reg. No. (1)	י ב	2060	Ω
ı	B)		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath ZU	Year	G. Mine of Death	
	Physici /Medic	_	Maynard	Zenter					gust 24, 20	05	4:50 a.	М
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of D	Peath	4c. County	of Death		
				dise Assisted Livi		If Under 1 Year	If Under 24	Catonsville Hrs. 8. Date of Birt	h		timore	ian
	Funeral		5. Social Security Number 6. Sec	/ Age (in yi M 2□F	rs. last birthday) Yrs.	Months Days		Min. (Month, Day	y, Year)	9. Birting Coul	place (State or Fore htry)	ign
	Director		212-09-2982 Usual Residence of Decedent		94			August 2	4 , 1911		Maryland	_
	yland now		10a. State 10b. County	10c.	City, Town or Lo	ocation	_			1	0d. Inside City Lim	
	B-1 st	tor	Maryland Hor	ward		E	llicott City	<u>.</u>			1 🗌 Yes 2 🜠 1	No
	or 28	Olre	10e. Street and Number			10f. Zip Code	ĺ		10g. Citizen of V	What Coul	ntry?	
	ath w 238	by Funeral Director	4399 Montgomery Rd.				2104	·	1	U.S		
	er de:	nue		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin ın, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	- 14. Had Blad	e - Amend ck, White,	ean Indian, etc.	
30	rs aft	Jy F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🙇 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify	<i>y</i> :	White	
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f show ita Macical Ever: it ar mast be notified at	edi	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/ln		
212	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done on DO NOT use retired	during most of f)	working	W	T Bun	nett & Co.	
7	d with	Com	12			Sales	man / V.I	ο,				
	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Suman	10)		
Maryland	Ment Ment arked	ဂ္ဂ	Frederick	A. Zenter			1		Catherine B			
<u>a</u>	2 shot and is m		19a. Informant's Name/Relationship (Ty	pe, Print)				r Rural Route Numbe			Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Englishment to inclined at one injury or other traumatic event, the Medical		Mr. Maynard C. Zenter, J 20a. Method of Disposition			6474 A.E. Mi esition (Name of	ullinix Rd.	Woodbine, Ma	aryland 217 20c. Location -		own State	
0	Pages 1 nent of H int: If ite		1 Suria 2 □ Cremation 3 □ F		cemetery, crei	matory or other place	ce)					
Baltimore,	t, Pa rtmer rtant: njury		' 4 Domation 5 ☐ Other (Specify)	6		n Memorial G		08/27/2005	Marri	ottsville	e, Maryland	_
Ra	Departing on the property of t		Musik after	let moos	2		uneral H	ome PA				
8760, <	Physician /Medical Examiner and the private an	dical Examiner	234. Part1. Enter the disease, or complishook, or heart failure. List only or mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	equence of):	•					Interval Between Onset and Death 5 days	5
O. Box 6	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3[□Ectopic pregnancy □ Other (specify)	,			te of deliventh	ery Day Year	
Vital Records, P.	Se un e	Completed by PI	Part II. Other significant conditions con <u>Congestive</u> H			inderlying cause giv	en in Part I.	23e. Did to	_	nbute to t	he cause of death? pably 4 □Unkno	
ပ	> 0 0	iete	Cardiomyo	pathu				24a. Was		Were auto	psy findings availa	ble
e Y	0 4 9	mo		1 00 11 9					rmed?	death?	mpletion of cause of)IC
<u>ra</u>	ician: Th certificate rector, pag	a a	25. Was case referred to medical				26. Place of	Death (Check only o			2070	
	y s	To B	examiner? 1 ☐ Yes 2 / N o	Hospital: 1 ☐ Inpatient 2	. ☐ ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursi	ng Home 5 Resid	dence 6° Oth	er (Specil	ASSISTED	
on of	Attending Ph r death. ector: After th by the funeral		27. Manner of Death 1 → SNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wor	y at k? Yes 2 □ No		now injury occur	red		
Division	after deatl	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		reet, factory, office		28f. Location (5 City or Tox		er or Run	al Route Number,	
	Hospita 4 hours Funeral ely filled	dical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred at the tire tire tire to the tire tire to the tire to	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	anner as s and due t	tated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. Licens			29d. Date signe	d (Month,	Day, Year)	
)	. ,,,,,		1 /2/1/80	1		HOI	2543	337	8.2	4-	05	
	10		30. Name and address of person who co	ompleted cause of death (I	Item 23a) (Type,	Print)		tarting Gat	ect w	OODB	WEMDY	79
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 1 20	32. Popiarar's Si				,				

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 28609 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 15, 2005 **Physician** Donald D. Asker 9:28 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9310 Woodberry Street Seabrook Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 2, 16 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F Yrs. Director 501-14-5109 1924 North Dakota Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "neturel", or items 23e or 28a-1 show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No **Funeral Directo** Maryland Prince George's Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9310 Woodberry Street 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or ite any injury or other treumetic event, the Medical Exerthes 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4+ Elementary/Secondary (0-12) Electrical Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chris Asker Orba Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Asker (Wife) 9310 Woodberry Street, Seabrook, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem. 8/22/2005 Crownsville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Sign thus of Funeral Service Licen 9013 Annapolis Road, Lanham MD 20706 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, shock, or heart failure. mediate Cause (Final **Physician** (ancer. disease or condition resulting in death) 40 99 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner signed by the attending physician and I be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ lar sease 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Abdominal 2 No 2 □ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending within 24 hours after death, To the Funerel Director: After 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier l 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi onel and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 31001 8/16/05 30. Name and address of person who Implete cause of death (Item 23a) (Type, Print) Stuart Turkewitz, M.D. 7500 Greenway Center Dr., Suite 430, Greenbelt MD 31. Date filed (Month, Day, Year) . Registrar's Signature-State AUG 1 7 2005 Registrar

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			For State Registrar	State of Mar		artment of I		Mental H	lygie Reg.	ne PNN5	28610
	Physici	an	1. Decedent's Name (First, Middle, Las.		T.	1		2. Date of		Paxor Year	3. Time of Death
	/Medic	al	Raymond	A,	Burc			August	<u> </u>	2005	4:45 P M
	Examir	ier	4a. Facility Name (If not institution, give Southern Maryland Hosp			Clinto	or Location of Death	1		4c. County of Death Prince Geor	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of I	Birth		ge's pplace (State or Foreign intry)
	Director		377 07 4702	ØM 2□F	93 Yrs.	Months	Hours Min.	February			ryland
	tand bw		Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	Maryland Prince Geor	rge's	Clinton						1 ☐ Yes <u>XXX</u> No
	h with the 23a or 28a 81 be not	Funeral Director	10e. Street and Number 8600 Mike Shapiro Driv	/e		10f. Zip Code 20735			10g.	Citizen of What Cou USA	untry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or Items 23e or 28e-1 show other traumatic event, the Medical Evantical must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3★Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes ���\No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2☐ No	Hispanic Origin? (S ean, Mexican, Puert Specify:	pecify Yes or o Rican, etc.)	No-	14. Race - Amer Black, White Specify:	
9	2 hour	ed b	15. Decedent's Edi	ucation	16a. Deced	lent's Usual Occu	pation		16b	. Kind of Business/li	
215	thin 72 e. an "na Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of wor d)	king			ŕ
21	filed within Hygiene. Athar than "		6 17. Father's Name (First, Middle, Last)		Self-	Employed_	1 40 14 11 11	(F) . A () .		Produce	2
and	d be fi	o Be	Frank Herman Burch				18. Mother's Nan Lulu Ber		ile, Maic	len Sumame)	
Maryland 21215-0036	2 should be filed and Mental Hygid Is markad othar aumatic avant, II	To	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	g Address (Street			nber, Cit	ty or Town, State, Zi	ip Code)
Ž	1 and 2 Health a tam 27 Is		Dolly Johnson / Daught	er	3726 S	outhern Av	enue S.E. W	ashingto	n, D	.C. 20020	
Baltimore,	0 0 = =		20a. Method of Disposition 1 XXBurial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ice)	Date	20c.	Location - City or T	own, State
tim			* 4 □ Donation 5 □ Other (Specify, 21. Signatural Funeral Service (Acens		Resurrectio		The second secon	19, 2005	5 C1	inton, Mary	land
Bal	permit. Departri Imports any inju		Je P. R.L		6		ill Road Ox	on Hill,	var	Funeral Hoy yland 207	45
	Pnysician /Medical Examiner	17	23a. Pairl. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Due to (or a. a.	iration		MON IQ	orrespiratory	arrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	al Examiner	if any, leading to immediate cause (Disease or injury	c.	consequence of):						
687	ficate to physical sthe to	edical		d							
O. Box	at the death certific by the attending p tached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify) _	у			23d. Date of deliv Month	rery Day Year
rds, P	ires tha signed d be de	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause gr	ven in Part I.		d tobacc	o use contribute to i	
Vital Record	(D CT	Completed						24a. We aut	topsy rformed	prior to co	opsy findings available ompletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🛶		Ott	26. Place of Dea				
of	ling After fune	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of	28c. Inju Wo	ry at	ome 5 ☐ Re 28d. Describ	_	6 ☐Other (Speci ijury occurred	fy)
Division	spital or Attanding ours after death. taral Diractor: After filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, stre (Specify)			28f. Location City or T	(Street own, St	and Number or Run ate)	al Route Number,
	Hos Fur ely	edical C	29a. Certifier (Check only one)	rsician: To the best of iner: On the basis of each and manner state	xamination and/or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occur	, and due to the rred at the time	e cause e, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier			29c. Licens	_			Date signed (Month,	
•			M. Yaahu	may 1	ND	D	06 52 9	99	5	117/201	05
2	(2)		30. Name and address of person who c		th (Item 23a) (Type,	Print) URVATT	POAN	205	CI	NTONIN	2EF064N
	Sta	te.	31. Date filed (Month, Day, Year)		s Signature	-0	- KUND	(3.07)		11/0/4	
	Regist		AUG 1 8 2005	Elem	s Signature			~			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Fannie B. Brown August 13, 2005 5:30p /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Health & Rehab Center Fort Washington Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer)
June 15, 1902

8. Birthplace (State or Foreign Country)
North Carolina 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 13€F 579-14-8602 103 Director Usual Residence of Decedent the Maryland r 28e-f show 10a State 10b. County 10c. City, Town or Location Maryland

10e. Street and N 10d. Inside City Limits Prince George Clinton 1⊠Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ral', or Itams 23a or Examinate De r 8410 Deegan Ct. 20735 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of the following the filed of Health and Mental Hygiene. Sent: If Itam 27 le marked other then "naturelt, or Ital Black. White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Black 3 ™ Widowed 4 □ Divorced other traumatic event, It a Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Boyce Jane Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Reginald E. Sutton/Grandson 8410 Deegan Ct. Clinton, MD. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. Resurrection Cemetery Aug. 20, 2005 ^¹ 4 □ Donation 5 □ Other (Specify) Clinton, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician yeas /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 ☐ Yes 200No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2**X**No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? of or Attanding Patter death. Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal 2 Medical Examiner: On the basis of examiner and manner stated. (Check only within 2 To tha F one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) August 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxima Berwa, M.D. 7700 Old Branch Ave. Suite 101, Clinton, M.D. 20735 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 1 8 2005 Registrar

3/0

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day August 12, 2005 **Physician** 1:40p M Willa Mae Bynum /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 1, 1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🝊 F Washington, D.C 577-68-2949 61 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Exerting partition at the politied at Maryland Prince Georges Suitland 1X Yes 2 □ No Director fhe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3920 Suitland Rd. #2 20746 united States items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☒ No Specify: Specify: Black Completed by 3 ₩ Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 Private other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be flit pertment of Health and Mental Hy cortent: If item 27 is marked oth injury or other traumatic event Be Willie H. Massey, Sr. Mamie Funderburk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terrance Massey /Son 6569 Ronald Rd. Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State pernit. Page Department Importent: If any njury or 8/18/2005 Maryland National Laurel, Md. * 4 ☐ Donation 5 ☐ Other (Specify)) 21. Signature of Funeral Service Lio 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 23a. Part 1. Einer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 2 Webs Immediate Cause (Final disease or condition resulting in death) Pnysician lumong /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Energy that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Gunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2E NO 1 ☐ Yes 2 1 NO or Attending Physicien: ours after death.

Neel Director: After this certifica
filled in by the funeral director., Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 7600 Comell AVE Taroma 2. Registrar's Signature State

Registrar

		•	1 - For State Registrar	State o	f Marylar		artment <i>rtificate</i>			ind M	ental Hy	giene Reg. No		05	28613
	Physici	an	1. Decedent's Name (First, Middle	, Last)			1				2. Date of Do			Year	3. Time of Death
H	/Medic		Francine					kei			August	F (3 6	2005	0509 4
	Examin	er	4a. Facility Name (If not institution		soita	1	4b. City, To	own, or Lo		Death	4.7	40	. County	of Death	
	Funeral		Johns Hopki 5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	Year I	If Under 2		8. Date of Bi	rth		9. Birthpla	ace (State or Foreign
	Director		578-64-1116	1□M 2🙀 F	58	Yrs.	Months	Days	Hours	Min.	April	28 1	947	Washi	ngton,DC
	and ww		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10	d. Inside City Limits
	Maryl -f sho	to	MD Prince	George's	Un	per Ma:	r1horo								1 Yes 2 □ No
	th the	irec	10e. Street and Number	deorge B		рет па.	10f. Zip C					10g. Ci	tizen of W	/hat Count	ry?
	23a c	Funeral Director	4801 Copley Lan	e			20	772				U.S.			
	er dez Items	une	11. Marital Status	Armed Fo			Was Decede f Yes, sp <i>eci</i> f	nt of Hisp y Cuban,	anic Orig Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	D-		e - America k, White, e	
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2-0	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show fre M. Jical Exa. illier i untite indiffical at	ted	15. Decedent (Specify only highes			16a. Deced	lent's Usual	Occupation	on ring most	of workin		16b. K	(ind of Bu	siness/Ind	ustry
2	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1	I-4or 5+)		kind of work DO NOT use				9	Dr	ivate		
2	Hygie Hygie ther th		17. Father's Name (First, Middle, I	2 yrs		Prote	ession				(First, Middle	1			
au	ld be ental ked o	To Be	William Hurd								Stepr		, Darriari	-,	
ary	shoul and M s mar	-	19a. Informant's Name/Relationsh	nip (Type, Print)				Street and	d Number	r o <i>r Rural</i>	Route Numb	er, City			
Σ	and 2 ealth a n 27 li	3	Warren Morris	/Friend		_			ne Up		Mar1bo	ro,	Mary	land	20772
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or items 23a or 28a-f show any injury or other traumatic event, it is Mudical Examinator unal be rediffied at ODGs.	Ì	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Removal from	1 .	Place of Dispo cemetery, cren	sition (Name natory or oth	er place)	İ		ate	20c. L	ocation - (City or Tov	vn, State
Ħ	t. Partmen rtant:		* 4 □ Donation 5 □ Other (Sp		Ri	verdale				/22/0	05 3. Jenl				ryland
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	Pnysician	, l	shock, or heart failure. List of Immediate Cause (Final disease or condition	,	taboliz		·dasi								Interval Between Onset and Death
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8760,	icate be executed physician and s the burial-transit	dical		d											
9	entifica ling ph	Med	IF FEMALE:									- 1			
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		come of pregnith 2 Feta ant at time of c	al death 3	Ectopic preg						23d. Date Mon	of deliver	y Day Year
o.	that the de led by the a detached t	Physician/Me	1 □ Yes → No 9 □ Unknown	9□ Unkno		200.11 5	Citiel (Spec	JII Y)							
٦,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Pi	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the ur	nderlying cau	ıse given i	in Part I.		23e. Did 1	obacco	use contri	bute to the	cause of death?
Vital Records,	w require been sig should b	ted t	Gangrene	of fee	et-						1 🗆	Yes 2	□No	3 🗌 Proba	bly 4 Onknown
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E H			Diabetes	Melita	ــــــــــــــــــــــــــــــــــــــ						1 Yes	ormed? 2LXNo	de 1	eath?	₩.
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Division of	or Atte ter de irecte n by ti	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place	of Injury - At h	ome, farm, stre	eet, factory,	office		2	Bf. Location (City or To	Street ar wn, State	nd Numbe e)	r or Rural	Route Number,
Ω	 Hospitel or Attending F 24 hours after death. Funeral Director: After etely filled in by the funer 		29a. Certifier 1 2 Certifying	- Physician To the	hant of my ton										
	To the Hospitel or within 24 hours afte To the Funeral Director completely filled in the Funeral Director of the Funeral Direc	edical	(Check only 2 Medical E	g Physician: To the Examiner: On the ba and man	asis of examina	ation and/or inv	estigation, in	tne time, n my opini	date and ion, death	n piace, ar n occurre	d at the time,	date and) and mar d place, a	nd due to t	ted. he cause(s)
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K	(3)	1	30. Name and iddress of person v					a	14.		Many				07
	Sta		31. Date filed (Month, Day, Year)	J)	egistrar's Signa	Nolfe 5	1/20-1	١٥٩	1117	1000	riany	(4/	y 6	<u> </u>	0
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** 22, 10:00 PM BELL-GROSS 2005 R. DARLENE Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/17/1948 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 TF 218-46-8486 Maryland Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State "natural", or Items 23a or 28a-f ahow 1 ☐ Yes 2 No York Delta Directo PA. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17314 216 Lakeview Drive United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) 2 should be filed with and Mental Hygiene. Supervisor Health Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lehr Ada McDaniel Leonard Hendry Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 190 Health itam 27 i John T. Gross /Husband Delta, Penna. 17314 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 N Burial 2 Cremation 3 Removal from State 8/26/2005 Madonna, Maryland 4 □ Donation 5 □ Other (Specify) Bethel Cemetery 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Service Licensee E.G. Kurts & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Emphsema 33 hrs **Physician** Chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Encephalopathy Chronic Completed respirator 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 €No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral D 1 Secritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22, 2005 2/33 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)/ Sweatman Upper Chesapeake 32 Pegistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28615 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician August 15, 2005 6:15 P M Rubin Barman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Spring Silver Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1⊈M 2□F Months Poland 80 19, 1924 Director 579-44-4899 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County show in then "naturel", or Itams 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director MD Montgomery Rockville 10n Citizen of What Country? 10f. Zio Code 10e. Street and Number 20852 27 Shagbark Court United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: 14. Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Importent: If item 27 Is marked other then "naturel, or Item in yelly or other treumatic event, the Medical Evantmen 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Jeweler Design/Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miriam Unknown Mayer Barman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Miriam Weiner, Daughter 11533 Twining Lane Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns 08-17-2005 Olney, MD ¹ 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License lla 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Intracerebral Bleed /Medical Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transil that initiated events resulting in death) Last Iding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2₩ No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2**1** No 1XXnpatient 2 ER/Outpatient his 28b. Time of Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 15, 2005 00024571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wheaton ind gin Ave 11501 Gens Weiner wo 39. Registrar's Signature 31. Date filed (Month, Day, Year) State 18 2005 Registrar AUG

Belding, Jean

State of Maryland / Department of Health and Mental Hygien 005 28617 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year SAMUEL BRICKEN 16 2005 1:00 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 → M 2 □ F Hours Min. 90 Director Yrs 579-01-3266 Oct. 17, 1914 Manhattan, NY Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show amportant: If item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5450 Whitley Park Terrace #304 20814 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Creative Design College (1-4or 5+) 12 Display Designer <u>Interior/Commercial</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Bricken ပ Hilda Ginsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mindell E. Bricken, Spouse 5450 Whitley Park Terrace, #304, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State King David Mem. Grdns 08-17-2005 Falls Church, VA `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Ul 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Pneumonia 5 Days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Acute-on-chronic renal failure 1 Yes 2 No 3 Probably 4√Qunknown Completed Severe cerebrovascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 🗀 No 1 ☐ Yes Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: ٩ 1 ☐ Yes 2 X No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division Injury 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 🖺 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗍 Homicide 24 hours a 152 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) Michael a. Westerman, M.D. D52451 August 16, 2005 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Westerman, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) . Registrar's Signature State 18 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene UU5

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month August 14, Sylvia F. BROIDA 2005 10:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Hebrew Home of Greater Washington Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1918 New York **Funeral** 1 M 2 F Director 069-16-3175 86 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f ehow any lojury or other treumatic event. The Medical Ever is activate to rutified at once. 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 3 X Widowed 4 ☐ Divorced Specify: white 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Fein Ida Boblowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Marian Broida, Daughter 3429 N. Druid Hills Rd. #0, Decatur, GA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/17/05 `4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, VA 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part Saffer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OSCLEROCIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 0 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No Vital 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: P 1 🗌 Yes Division of З□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Aftar Hospital or Attending 1 Alatural 2 Accident 5 Pending death. investigation 1 🗌 Yes 2 No after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 4 mound NW 30. Name and address of person who completed cause of deat litem 23a) (Type, Print) MA 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 18 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland		artment of F		nd Mental Hy		2005	28619
			1. Decedent's Name (First, Middle	, Last)					2. Date of D	eath		3. Time of Death
	Physici /Medi		Sherrie		Butler				Month Augus	Da t 13	-	5:00 P ^M
	Examir	er	4a. Facility Name (If not institution		iber)		4b. City, Town, or			4c	. County of Death	1
			10404 Gatewood 5. Social Security Number		7. Age (In yrs. la	et hirthday	Silve If Under 1 Year	r Spri]	Montgome	
	Funeral Director		219-68-6715	1 □ M 2 □xF	50	Yrs.	Months Days		Min. 8. Date of B (Month, D		Wash	nplace (State or Foreign untry) ington, DC
	D.		Usual Residence of Decedent						3/10/	1933		
	arylar show	<u>-</u>	10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	28a-f	Director	Maryland Monts 10e. Street and Number	gomery	Si	lver S	pring 10f. Zip Code			10- 0	tizen of What Cou	1 Tes 2 No
	3a or		10404 Gatewood	Terrace			20907			_	ited Sta	,
	death ma 2:	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S	6. 13.		ispanic Origin	? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer	ican Indian,
98	or its	/Fu	1 ☐ Never Married 2 ☑ Marri	ied 1 Tes 2	2 X No		r Yes, speciny Cuba 1 □ Yes 21&1 No	Specify:	uerto Hican, etc.)		Black, White	
Ö	72 hours after death with the Maryland natural', or itama 23a or 28a-f show dical Evantifer must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	tes:						Specify: Wh	
75		Completed	15. Decedent (Specify only highes	t grade completed)		16a. Deced (Give	tent's Usual Occup kind of work done o DO NOT use retired	ation during most of d)	working f		ind of Business/l	•
212	e filed within II Hygiene. other than "	omi	Elementary/Secondary (0-12)	College (1-	4or 5+)		Resource				orts Au	n Washington thority
pu	be filed tal Hygid d other event,	Bec	17. Father's Name (First, Middle, I	ast)				18. Mother's	Name (First, Middle			
yla	2 should be and Mental is marked (aumatic ev	To	Leonard Angel					Caroly	n Webb			
Maryland 21215-0036	12 sh h and 7 tam traum	ų l	19a. Informant's Name/Relationsh Edward Glenn Bu		150				r Rural Route Numb			
	is 1 and 2 of Health a item 27 ta other trav		20a. Method of Disposition	tier, spot					Date		ocation - City or T	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta important: If item 27 ia marked any injury or other traumatic enone.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				sition (Name of natory or other place In Cremet		3-17-2005			
alti	Departm Departm Importar any injur		21. Signature of Funeral Service I		0.0				Hines-Ri			
Ö	P P P P P P P P P P P P P P P P P P P) alon)	, Dom	Ille							ng MD 20904
8760,	/Medical Examiner the purish-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, ox shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Nucl Due to (o b. Due to (o	r as a conseque	ence of):	Cuny	(Im)				Interval Between onset and Death,
.O. Box 6	death certifi e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Fetalo nt at time of dea	death 3	Ectopic pregnancy Other (specify)			4	23d. Date of deliv Month	ery Day Year
Vital Records, P	es es	by	Part II. Other significant condition	ns contributing to dea	ith but not result	ting in the ur	iderlying cause give	an in Part I.	23e. Did	/		he cause of death?
9C0	e law requ has been je 2 shoul	Completed							24a. Was		24b. Were auto	ppsy findings available
<u> </u>		Com							— auto perfe i 1 ☐ Yes	ormed?	death?	mpletion of cause of
/ita	ilcian: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	11					Death (Check only			
	무 무 등	2	1 ☐ Yes 2 No 27. Manper of Death	Hospital: 1 Ing		R/Outpatient		4 Nursin	g Home St Resi			5/)
o	Attending F ir death. ector: After by the funer	tlon	1 Natural 5 Pending 2 Accident investig	(Month,	Day Year)	Injury	28c. Injury Work	rai (? (es 2 □ No	28d. Describe	now injur	у оссигеа	
Division of		ertification;	3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place o	f Injury - At hom , etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (City or To		d Number or Rura)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	O	29a. Certifier 1 Certifying	Physician: To the b	est of my knowl	ledge, death	occurred at the tim	e, date and ol	ace, and due to the	cause/e)	and manner as s	tated
	- '44 - O	edical	(Check only 2 Medical E	xaminer: On the bas and manne	is of examination	on and/or inv	estigation, in my op	pinion, death o	occurred at the time,	date and	place, and due to	o the cause(s)
	vithin To the	Z.	29b. Signature and little of certifier	21			29c. License	number			e signed (Month,	
(1	5)5		1/ma	Ma	~		De	7182	8	A	ugust 16	, 2005
7			30. Name and address of person v				•	"	_			
			Clara S.P. Chan 31. Date filed (Month, Day, Year)					#308 B	owie, MD	2071	6	
	Sta Registra		·	2005	gistrar's Signatu	100	all I					

			1 - State of large St	Maryland / Dep	partment of l	lealth and M Death	lental Hyg	iene 2005	28620
	Physic /Medi		Decedent's Name (First, Middle, Last) HELENA	VIOLA BAXTI	ER		2. Date of Deat August	1 ^{Day} , 2005 ^{ar}	3. Time of Death 7:43 AM
	Examir		4a. Facility Name (If not institution, give street and number Kline Hospice House	er)	4b. City, Town, o	r Location of Death		4c. County of Deat	
	Funeral Director		214-28-5988 ¹□M 2√2F	Age (In yrs. last birthda) 85 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 8,	9. Birt 1920 Mary	hplace (State or Foreign untry) Land
	Aaryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town or I					10d. Inside City Limits 1 Yes 2 No
	h with the P 23a or 28e-	Funeral Director	10e. Street and Number 615 Himes Avenue	rrederi	10f. Zip Code	703	10	Og. Citizen of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, it a Madical Examinar must be inclined all ance.	by Funer	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 If Yes, Give 1 Vear or Date	\$2 X No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: T.T.	e, etc.
Maryland 21215-0036	thin 72 hour e. an "naturel Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of worki	ing	16b. Kind of Business/	nite
and 21	be filed wil htal Hygien ad other the event, ILE	Be	6 17. Father's Name (First, Middle, Last) Wilbert Josiah Miller		Homemaker	18. Mother's Name			
	and 2 should saith and Men n 27 is marke	To	19a. Informant's Name/Relationship (Type, Print) Barbara Kemmerer (Daughte			and Number or Rura		Ley City or Town, State, 2 laryland 21	
Baltimore,	Pages 1 ar nent of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☒ Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cre	_	(e)	Date 2	20c. Location - City or	Town, State
Balt	permit. Page Department of Importent: If any injury of		21. Signature of Funeral Service Licensee	Osef & R	OBERT E. 15 EAST M	DAILEY & AIN ST.,	SON, FUNE	ERAL HOMES, MD 21788	Ρ.Δ.
	Physician /Medical		23a. Part1. Enter the disease of complications that caus shock, or heart failure. List entry one cause on each immediate Cause (Final disease or condition resulting in death) Due to (or a part of the cause of cause on each immediate Cause (Final disease).		oter the mode of dyin			st,	Approximate Interval Between Onset and Death
	Examiner pean	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):					
68760,	ficate be executed g physician and is the burial-transit	edical Exa	regulting in death\ Leat	as a consequence of):					
O. Box	The law requires that the death certific tle has been signed by the atlending p oage 2 should be detached for use as	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliving Month	rery Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause give	en in Part I.		acco use contribute to	
Vital Records,	(G CT	Completed					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
o	y Physicien: The strain of this certificate eral director, pag	n: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpa 27. Manner of Death 28a. Date of In	jury 28b. Time o		4 Nursing Hon		ice 6. Other (Speci	M) Hospice
UIVISION	el or Attending P s after death. I Director: After t d in by the funere	Certification;	1 Natural 5 Pending (Month, D	lay Year) Injury njury - At home, farm, state. (Specify)		′es 2□No		eet and Number or Run	al Route Number,
7	Hospita 4 hours Funere ely fille	edical Ce	29a. Certifier (Check only one) 1. Certifying Physician: To the best and manner and manner	or examination and/or in	h occurred at the tim Vestigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the I	Me	29b. Signature and title of certifier		29c. License	number 035152		d. Date signed (Month, eptember 2	**
	5		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print) Center St	- Thu	e most,	MO 217.	8-8
	Sta Registra		31. Date filed (Month, Ref. Ger.) 9 2005 32. Ref.	rar's Signature	spectus				

			1 - For State Registrar	State of M	arylan		artment o			-	giene Rog. No [005	28621
T.	Physici	an	1. Decedent's Name (First, Middle,	Last)	-					2. Date of De	ath Day	Year	3. Time of Death
	/Media	cal	Catherine 4a. Facility Name (If not institution,	nive street and number		mming		n, or Location		Hugus		nty of Death	1305 M
1	Examir	ier	14226 Windy					Mar		٥			ingo's
	Funeral			. Sex 7. Ag		last birthday)	If Under 1 Ye Months Da			8. Date of Birt (Month, Oa	h y, Year)	9. Birthp Coun	lace (State or Foreign
	Director		056-1/2-67111	10 M 2A1F	87	Yrs.				01-06	-1918	West	VA.
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				-	1	0d. Inside City Limits
	8a-fs	Director		Georges	UE	pper N	iarlbo	ro					1X Yes 2 □ No
	with the	Dire	10e. Street and Number 14426 Wendy O	ak Circle	4		10f. Zip Cod	^{le} 20772			10g. Citizen	of What Coun	try?
	ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Decedent		rigin? (Spec	rify Yes or No		Race - Americ	
92	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show deat Examinar must be notified at		1 Never Married 2 Marrie	Armed Forces? 1 ☐ Yes 2 🕅 If Yes, Give			f Yes, specify 0 1 ☐ Yes 2127 i			tican, etc.)		Black, White,	
903	"natural",	ed by	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's	Year or Dates:			dent's Usual Oc					Bla	
215	C 2 10	plet	(Specify only highest Elementary/Secondary (0-12)		5.1)	(Give	kind of work do DO NOT use re	ne durina mo	st of workin	g	IBB. KING O	f Business/Ind	lustry
217	filed within Hyglene. other than "	Completed	12	•	J+)	N	urse				Pri	vate	
Maryland 21215-0036	be d ag	Be	17. Father's Name (First, Middle, La	N.*						(First, Middle, Ware	Maiden Sum	name)	
IZ	d 2 should be the and Menta 7 is marked traumatic ex	၉	Floyd Bundr 19a. Informant's Name/Relationship			19b. Mailir	ng Address (Str				er. City or Toy	wn. State. Zip	Codel
	12 ha 7 Is		Samuel Hughe	s, Son			_						20772
Baltimore,	of H of H if ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from State	,c	emetery, crer	sition (Name of natory or other	place)		ite		on - City or To	
tim	Pa nen ant; ary		`4 □Donation 5 □ Other (Spe	cify)	U1.	esape	rv		8–18–			ville	
Bal	permit. Departr Importa eny Inji		21. Signature of Funeral Service Li	conser dina)	Ŕ	Name and Ad eese I	rcfes	Sion	al Fu	neral	Serv	ice
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	ly one cause on each li	no.	h. Do not ent		dying, such as	s cardiac or	respiratory ar	rest,		Approximate
	Physician		Immediate Cause (Final disease or condition	- Atheros	sule	evotic	Carol	EVASO	ula	1 Hear	* Dis	ease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as									
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):							
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	С.									
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):							
8760,	physic physic the b	dical	•	d									
Вох 6	death certific e attending p id for use as i	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. I	Date of delive	rv.
	0 0 0	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregna Other (specify					Month	Day Year
P.0	that the di ed by the detached	Physicia	9 ☐ Unknown Part II. Other significant condition		ut set see	ulting in the	- dash dan an una	aven in Best	1	220 Did to	haaaaaa a		e cause of death?
ds,	es pe	b	Part II. Other significant condition	a contributing to death t	ot not res	ulting at the ul	idenying cause	given in Part	1.		es 2□No		ably 4 Unknown
COL	> 11 0	ompleted								24a. Was	an 24	b. Were autor	osy findings available
Re	0 4 0	omo								autop perfor	med?	death?	npletion of cause of 2□ No
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of	Phyer this ral di	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatien	1 3 DOA	Other: 4 N		e 5 Resid)
	ing After une	tlon	1 Natural 5 Pending 2 Accident investiga	(Month, Da	y Year)	Injury	1	Work? □ Yes 2 □		od. Describe ii	low injury occ	unea	
Division		ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At ho	ome, farm, str	eet, factory, offi	се	28	St. Location (S City or Tow		mber or Rura	l Route Number,
Ō	spital or ours afte neraf Dir filled in	O		d.					1				
	Q = = >	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of my kno f examina ated.	wledge, death tion and/or in	occurred at the restigation, in m	e time, date a y opinion, de	nd place, ar ath occurred	nd due to the o d at the time, o	ause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	4.4.0-			29c. Lic	ense number		3	29d. Date sign	ned (Month, I	Day, Year)
0	(2)		Salvode	Alesta	Do		1	10055	921		Acquist	11,2	971
K	(2)		30. Name and address of person with SA(VAO) / Sy/V	ster, 3001	leath (Item	1 23a) (Type,	Print) Dri-	re, c	Lover	ly 1	ens 1	Mrs d	
	Sta Registr		29b. Signature and title of certifier 30. Name and address of person with the service of the se	05 Registr	ar's Signa	ho	W	_/					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, For State Registra 28622 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** August 16, Mary Elizabeth Campbell 2005 12:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Healthcare Adelphi Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year! 9 May 4, 1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Hours 1 □ M 2 🔀 F Washington DC 577-16-1057 86 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State r than "natural", or Items 23s or 28s-f show If a Medical Exterior must be rutilled at 1 Tres 2 No Directo Maryland | Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9885 Greenbelt Road 20706 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 12 should be filed withir h and Mental Hygiene. 7 Ia marked other than College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Cook George Donaldson Pages 1 and 2 should be ment of Health and Menta tant: If item 27 Is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Box 336, Union Mills, NC 28167 Donald Campbell (Son) or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State

¹ 4 Donation 5 Other (Specify) permit. Page Department o Importent: If any injury or Rock Creek Cemetery 8/19/2005 Washington, DC 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signaty 9013 Annapolis Road, Lanham, MD 20706 Pin1. Enter the disease, or confications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Congestive Heart Failure resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. the 9 Unknown signed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary disease been Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D55559 August 16, 2005 4.12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, Suite 316, Greenbelt, MD Thomas Maslen, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 1 7 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 28623 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16, Carolyn Springston Colborn August 2005 11:20 a[™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 3670 Charlie Bill Place Indian Head If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. July 25, 1920 West Virgin: 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2**X**)F 85 235-22-3099 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23e or 28e-1 show amy injury or other traumatic event. If a Medical Exact the resulting an once. 1 ☐ Yes 2 No Director Maryland Charles Indian Head 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20640 3670 Charlie Bill Place U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify: White Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) 2 Accountant U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Springston Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20640 Md. Paul E. Colborn 3670 Charlie Bill Place, Indian Head, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) August 18, 20 05 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens Waldorf, Maryland 4 □Donation 5 □ Other (Specify) Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, 21. Signature of Funeral Service Licenses 20640 M00668 Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the creef, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, than you have been go to mine classe. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably ↓ Phknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2/2 No certificate 1 Yes 2 No 1 Yes or Attanding Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 1 Yes 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 2 ER/Outpatient Sil 27. Manner of Death 1-1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after To the Funaral Direct 4 T Homicide Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) istrar's Signature AUG 1 8 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer 28624 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 8:10 AM Rosalle August 6,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 351-Triadelphia If Under 24 Hrs. Hours Min. M:11 Rd ar Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 1 F Days Months 220-32-025 Yrs Director ug. Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show th and Mental Hygiene. ?7 is marked other then "natural", or liems 23a or 28a-1 shov traumatic event, the Medical Expr. directual be notified at 1 Yes 2 □ No **Funeral Director** arksville Howar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 riade Road 02 Phia Mill 5 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK Restaurant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Milliam ပ Oswald Elizabeth thha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Polumbia, Manyland O. Box 502-Denise ephus 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. Richards Mem, Park 8 112/05 Easton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P.A. 510 washington St. Cambri MD,21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DION Physician METASTAN /Medical Due to (or as a consequence of): Examiner S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and I-transit or Attending Physician: The law requires that the death certificate be executed PER Due to (as a consequence of) physician a s the burial-P.O. Box 68760 Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 2/40 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 ☐ Yes director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther: 4 Nursing Home 5 Sidence 6 Other (Specify) 1 🗌 Yes 2 / No 3□ DOA this s after death.
I Director: After this of in by the funeral d 28b. Time of Injury 27. Manner of Death

1 Natural

2 Accident 28d. Sescribe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🔲 Suicide Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Directompletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4246J 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5450 KNOIL WETH DU SUITE 200A WILLIAM SANAY MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 Registrar

Ammend #1,8/22/05, per FHDR, HCHD, dk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrer	State of	Maryland / Depa	artment of H			giene Reg. N 2 () (15	28625
	Physici /Medio		1. Decedent's Name (First, Middle, La Fredric M. Cunnir Frederic M. Cun	st) ngham ningham				2. Date of Dea Month August	ath Day	Year	3. Time of Death 7:35 P
	Examin	er	4a. Facility Name (If not institution, giverally Casey House		per)	4b. City, Town, or Rockvill	Location of Death		4c. County		
	Funeral	_	5. Social Security Number 6. S		Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birtl	Montgo	9. Birtho	lace (State or Foreign
	Director		207-22-8224 Usual Residence of Decedent	M 2□F	72 Yrs.	Monuis Days	Hours Min.	(Month, Day Aug 31		Penn	sylvania
	yland Iow		10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	e Mar Sa-f st	ctor	PA Mifflin		Mt. Union						1 ☐ Yes 2 📉 No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	Jeath The 23	erai	10 Lower Country	12. Was Decede	ent Ever in U.S. 13.1	17066 Was Decedent of Hi	spanic Origin? (Spa		JSA 14. Race	e - Americ	an Indian.
920	urs after or itar	by	1 ☐ Never Married ②☐Married 3 ☐ Widowed 4 ☐ Divorced	Amed Force	es? □ No	f Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexican, Puerto Specify:	Rican, etc.)	Blac	white,	etc.
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any Injury or other traumatic avant, I'm Modical Examiner must be notified at once.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. Decec (Give	dent's Usual Occupa kind of work done o DO NOT use retired,	lurina most of worki	ing	16b. Kind of Bu		
	tiled wit Hygiene othar tha ant, Ir v	Соп		4	Accou	ntant			Oil Com		
Maryland	d be till ad ott ad ott	Be	17. Father's Name (First, Middle, Last, C. Brandon Cunnin				18. Mother's Name Kathleen			θ)	
ary	should nd Men marka umatic	2	19a. Informant's Name/Relationship (_	19b. Mailir	ng Address (Street a				State, Zip	Code)
	and 2 salth a n 27 is		Michele N. DiFran	co/daugh	ter 2706	Starkey D					
altimore,	Pages 1 nent of He int: If itar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	e) Augu	oate ist 19,	20c. Location -	City or To	wn, State
Ħ	artmen artmen ortant: Injury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Light 		W. Arunde	1 Cremato	ry 200)5 C	denton,	Mar	yland
Ba	permit. Departr Importa any Inji		Beverly	Hell		.Name and Addres ing Home					784 • MD 21029
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau one cause on eac	sed the death. Do not enti-	er the mode of dying	g, such as cardiac o	or respiratory arr	est,	1116	Approximate Interval Between
	Pr ysicia n /Medical		Immediate Cause (Final disease or condition resulting in death)		astoma Multi	forme					Onset and Death
	Examiner			Due to (or	as a consequence of):						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of):					_	
	and I-trans	Examin	that initiated events resulting in death) Last	c	as a consequence of):						
8760,	icate be executed physician and s the burial-transit	dical E		d	as a sonsequence on.						
9	rtificate ng phy as the	Medic	IS SERVALE.	. d							
Вох	The law requires that the death certific ate has been signed by the attending F bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 □Fetal death 3 □	Ectopic pregnancy			23d. Date Mon	of delive	ry Day Year
Ö	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐ Unknow		Other (specify)					Day Tour
S,	es that igned b	by Pi	Part II. Other significant conditions c	ontributing to deat	h but not resulting in the ur	derlying cause give	n in Part I.	23e. Did tot	pacco use contri	bute to th	e cause of death?
ord	w require been signature							1 🗆 Ye	s 2 No	3 🗌 Proba	ably 4 □Unknown
Records,	has b	Completed						24a. Was a autops perforr	y pr	rior to con	osy findings available appletion of cause of
Vital		င္ပ	25. Was case referred to medical				Of Disease Passible	1 Yes 2	2 □ X No 1	eath?	2 No
	Q 50	To B	examiner? 1 🗆 Yes - 2X) No	Hospital: 1 🔲 Inpe	atient 2 ER/Outpatient	3□ DOA Othe	26. Place of Death r: 4 □ Nursing Hor	_		r (Specify	Hospice
o u	ding Ph n. Atter th funeral		27. Manner of Death 1X Natural 5 □ Pending		njury 28b. Time of Day Year) Injury	28c. Injury Work	at 2	28d. Describe ho			•
Division of	or Attand after death Director: / in by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		Injury - At home, farm, stre		es 2 No	28f. Location (St.	reet and Numbe	r or Rural	Route Number
2		Certification;	4 Homicide determined	building,	etc. (Specify)	ot, lastery, ornes		City or Town	, State)	, or rigial	riodia rantbar,
	To tha Hospital or within 24 hours afte To the Funaral Dir completely filled in	edicai (29a. Certifier (Check only one)	ysicien: To the be niner: On the basis and manner	est of my knowledge, death s of examination and/or inv stated.	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the ca	ause(s) and man ate and place, ar	ner as sta nd due to	ated. the cause(s)
	To the within 2 To the complete	ž	29b. Signature and title of certifier	M	2	29c. License	number	25	9d. Date signed	(Month, E	Day, Year)
3	41		calla	in		041	218		8/18	10	5
5)	E. 6-1		30. Name and address of person when Charles Harrison,				Poolses 11	e MD 2	N855		
	Sta	_	31. Date filed (Month, Day, Year)	32. Re	strar's Signature		ROCKVIII	.e, rid 2	رروں		
	Registra	ar	AUG 1 9	2005	sew & B	DEALL!					

			For State Registrar	State	of Maryland /	Depa Cer	artment e rtificate	of Hea	alth and eath	Mental H	ygien Reg. N	200)5	286	26
ŀ	Physicia	an	Decedent's Name (First, Middle, La Diane Carter	st)						2. Date of D Month	D	ay	Year	3. Time of	
	/Medic Examin	al	4a. Facility Name (If not institution, giv	e street and n	umber)		4b. City, To	own, or Loc	cation of Dea	August		c. County		6:30	P M
	Examin	ei	Randolph Hills Nu				Silver	_	_		M	ontgo	mery		
	Funeral Director		5. Social Security Number 6. S 578-58-1705	ex □M 2 X 1F	7. Age (In yrs. last I	oirthday) Yrs.			Under 24 Hr dours Mir		irth lay, Yea 194	P3 .	Count	ace (State on ng ton	_
			Usual Residence of Decedent							ildy 0,					
	show	70	10a. State 10b. County Maryland MONTGOME	QΥ	10c. City, To								10	ld. Inside Ci 1 ☐ Yes	
	the M	Director	10e. Street and Number		DIIVE	. БР	10f. Zip C	ode			10g. C	itizen of W	/hat Count		21
	h with		11805 Dewey Road				2090	6				USA			
	tams	Funeral	11. Marital Status	Amed	cedent Ever in U.S. Forces?	13.	Was Deceder If Yes, specify	nt of Hispa y Cuban, N	nic Origin? Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0-		- America k, White, e		
39	urs afte	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes If Yes, 0 Year or	3 2 No Sive X Dates:		1□Yes 2¶	₹ No S	Specify:			Specify:	Bla	ck	
Maryland 21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gr			(Give	dent's Usual (done durir		orking	16b.	Kind of Bu	siness/Ind	ustry	
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d 2	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last		A	\$815	itant			ame (First, Middi				JOIS_	
ylar	Suld be Menta arked etic av	To E	Howard Carter							eth Gord					
Mar	d 2 shuth and 7 is m		19a. Informant's Name/Relationship (Mr Marc Jasper-S							Ru <i>ral R</i> oute Num Jer Spri		·		Code)	
<u>6</u>	t Heal		20a. Method of Disposition		20b. Place	of Dispo	sition (Name natory or other	of	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Date		Location -		vn, State	
altimore,	Page ment o ant: If ury or		1 ☐ Burial 2 🔯 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci						ory08,	/19/2005	Bre	ntwo	od, M	D	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or all print traumetic avant, the Modical Examinator ust be notified at once.		21. Signature of Fullera Service Lice	nsee) at	S:	imple 7	Tribu	ite Fu	neral an ke; Rock	d Cr vill	emati	ion C	enter 52	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that one cause or	t caused the death. D	o not ent	er the mode of	of dying, s	uch as cardi	ac or respiratory	arrest,	,		Approximat Interval Bet Onset and I	ween
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9	ertifica ling ph e as th	Medi	IF FEMALE:	00- 16							I				
Вох	eath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregnancy birth 2 Fetal dea gnant at time of death		Ectopic preg					23d. Date Mon	of deliver oth	,	/ear
0	that the de led by the a detached f	hysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Uni	known										
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٥٥		-	27. Manner of Death	28a. Dai		. Time o		: Injury at Work?		28d. Describe					
sior	Attanding ir death. actor: Afte by the fune	catic	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	n			М	1 🗌 Yes	2 🗆 No		(a. 1)				
Division	in Dirt	Certification:	4 Homicide determined	280. Pla	ce of Injury - At home, Iding, etc. (Specify)	farm, sti	reet, factory, o	office		28f. Location City or To			er or Rurai	Route Num	ber,
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	r		30. Name and address of person who Ghousia Sultana 1					C 4 1 +	28 Cn	ing MD	2004	36			
	Sta	te	31 Date filed (Month, Day, Year)					STIVE	er Spr	THE, MID	2090	סנ			
	Registr		AUG 18 2	005	Registrar's Signature	RO	GACA!								

State of Maryland / Department of Health and Mental Hygiene 2005 28627 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 12,2005 **Physician** ROBERT COLEMAN, 1355 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY Rockville Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 16, 1931 9. Birthplace (State or Foreign Country) N. Carolir 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F Carolina 73 410-42-1880 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or itama 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Completed by Funeral Director Rockville Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 U.S.A. Bel Pre Road 4612 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itama 23s array injury grother traumatic event. It is Medical Examiner must once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Mary Portion No. If Yes, Give 5 1 ☐ Never Married 250 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 51-75 Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montg. Co. College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Driver 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta Turner Robert Coleman, Sr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4612 Bel Pře Rd., Rockville, MD 20853 Elise Coleman (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Ington Nat'l Cem 8/31/05 Ft. Myer, VA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licens 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metastatic Pancreatic Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 0 1 ☐ Yes 2 ☐ No this After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death,

To the Funeral Director: A
completely filled in by the fu investigation 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide à 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature D41218 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd., Rockville, MD 20855 Charles Harrison, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 18 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005

			1 - State Registrar	Cer	rtificate of	Death	Re	4 U U J	28628
	Physici /Medi		Decedent's Name (First, Middle, Last) Lillie Mae Conner				2. Date of Death Month August	h Day Year	3. Time of Death 9:10 P M
	Examir		4a. Facility Name (If not institution, give street and number) 38245 Green Way		Mechani	or Location of Death		4c. County of Deat St. Mary	s
	Funeral Director		5. Social Security Number 219-74-5213 6. Sex 1 M 2 F 7. Age 1 Usual Residence of Decedent	96 Yrs. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 31,	, 1909 Wasi	hplace (State or Foreign buntry) nington, DC
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show dicel Evar, if we invast be incillised at	ector	Maryland St. Mary's	10c. City, Town or Lo	nicsville	:		- 1	10d. Inside City Limits 1 ☐ Yes 2 No
	s 23a or 2	Funeral Director	38245 Green Way		10f. Zip Code 20659			0g. Citizen of What Co	ountry?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Ever if all registed at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent t Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	lo li	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WI	
21215-0036	within 72 h ene. than "natu in Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	+) (Give life. L	lent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	ing	16b. Kind of Business/l	Industry
	uld be filed fental Hygie rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) James Owens	поше	emaker	18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
Maryland	and 2 should ealth and Men n 27 Is marke ier treumatic	-	19a. Informant's Name/Relationship (Type, Print) James Conner/son					City or Town, State, Z	
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1	20b. Place of Dispos	sition (Name of	(a)	Date 2	20c. Location - City or 3	Town, State
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Licensee						neral Home, te Hall, MD
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68760,	certificate be executed iding physician and use as the burial-transit	/Medical Examiner	cause. Entar Underlying Cause (Disease or Injury that initiated events	a consequence of):	custry	drei	·		- / -
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Division	itel or Atti rs efter de el Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, stre (Specify)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	ral Route Number,
	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fo	Medical	29a. Certifier (Check only one) 2 Medical Examinar: On the basis of and manner stal	examination and/or invi	estigation, in my of	pinion, death occurre	ed at the time, dat	te and place, and due t	to the cause(s)
	To To	<	29b. Signature and title of certifier	he	29c. License	e number	290	d. Date signed (Month,	Day, Year)
3	b 5		30. Name and address of person who completed cause of de Leon Berube, 28170 Old Vi	llage Rd.,	Mechanic	sville, N	D 20659	<i>y</i> - <i>y</i>	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Refistra AUG 1 9 2005	r's Signature	bartes				

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Function Director Dir	-	/Medic	al				mber)		4h City T	Town or	Location o	of Death	8				
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Use Description of Figure		Funeral		5. Social Security Number	er 6. S	ex		last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9 Ridho	ace (State	or Foreign
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			ë.		i □ Pending	28a. Date (Mo	e of Injury onth, Day Year)					751-	28d. Describe	how injury o	ccurred		
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. Item Ch. SISC in the Brown Red Surte 201 Eller, else 31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature	_	Hospital 24 hours: Funaral itely filled		(Check only 2	Certifying P	miner: On the	basis of examin	owledge, dea ation and/or i	th occurred	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the	e cause(s) ar , date and pl	nd manner as s ace, and due t	tated. o the cause	(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hulter Ch. SISG in the Brown Red Surte 201 Elteridge State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature Projectors ALIC 2 2 2005		o the	Mec	100	e of certifier				29	c. Licens	e number			29d. Date s	signed (Month,	Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene 2005 1 - For Stata Registrar 28630 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Byron Elwood Cooper 20 /Medical 08 05 0611 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death eninsula egional Medical Center Sbury If Under/24 Hrs. WIGOMICO If Under 1 Year 8. Date of Birth (Month, Day, Y 2/20/22 **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1[XM 2□ F Hours Min 83 221-18-7598 Director Delaware Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Sussex 1 ▼Yes 2 No Director Milford 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 102 Bridgeham Ave. 19963 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2(X) Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elwood Cooper Vera Raughley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenna L. Cooper/wiff 102 Bridgeham Ave., MIlford, DE 19963 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any injury or once. Milford Community 8/23/05 Milford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rogers Funeral Home 301 Lakeview Ave. Milford, DE 19963 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 WK /Medical Due to (or as a cons Examiner remenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last INK Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical as the IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 21 No 1 ☐ Yes 2 \(\text{No.} Division of Vital 1 Tyes director. 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only To the 29b. Signature and title of ca 29c. License number 29d. Date signed (Month, Day, Year) D 55658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regional Medical Center Salisbury Ma FRANK PEDINSULA 31. Date filed (Month, Da) 32. Fegistrar's Signature Registrar

			1 - For Stete Registrar	State of Maryland	/ Depa	rtment of H	ealth and I Death	Mental Hygi	en 2005	28631
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		GLORIA	E. DRIVER	2			Month AUGUST	Day Year 15 2005	7:01 P M
	Examin		4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			SOUTHERN MARYLA	ND HOSPITAL		CLINTON			PRINCE G	EORGE 'S
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		216-30-4429	1 □ M 2 □ X F 7 1	Yrs.	Months Days	Hours Min.		4 1934 MAF	
	P .		Usual Residence of Decedent							
	show	_	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Ba-f s	ct	MD PRINCE	GEORGE'S FT	. WASH	INGTON				1X□Yes 2□No
	ith th	Olre	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a	Funeral Director	6801 BOCK ROAD			20744			U.S.A.	
	er de	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
36	within 72 hours after death with the Maryland ena. than "natural", or Items 23a or 28a-f show the Modeal Examiner must be notillied at	by Fi	1 Never Married 2 Married	If Yes, Give	1	☐ Yes 2፟X No	Specify:		Specify:	
8	hour ural	D D	3 ☐ Widowed 4 ☒Divorced	Year or Dates:	10- D1			1	BL	ACK
7	n 72 nat	Completed	15. Decedent's l (Specify only highest g		(Give k	ent's Usual Occupa ind of work done of ONOT use retired	turina most of wor	rking	6b. Kind of Business	/Industry
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2	filed Hygir ther ant, I		17. Father's Name (First, Middle, Las		DALLED	CLLIKK	18. Mother's Nar	ne (First, Middle, N		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notilitied at once.	To Be	FRANKLIN DAVIS					ACKSON	,	
ar)	sho and t		19a. Informant's Name/Relationship	(Type, Print)	•				City or Town, State,	r/
Σ	and 2 salth 27 I		JAMIE DRIVER/DAU	GHTER	9240	ANNAPOLI	S RD. LA	NHAM, MAR	YLAND 207	06
altimore,	of He fiten roth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	000	ce of Dispos netery, crema	ition (Name of atory or other place	θ)	Date 2	20c. Location - City or	Town, State
<u>Ĕ</u>	Pag nent ant: I		`4 □Donation 5 □ Other (Spec		COLN I	PARK CEMI	E. 8/23	3/05 R	OCKVILLE,	1ARYLAND
alt	permit. Departrimports Imports any inju		21. Signature of Funeral Service Lic	ensee	22.	Name and Addres	s of Facility	B. JEN	KINS FUNER	AL HOME
<u>m</u>	9 Q E # 9		K. D. Hu	-hal	74	74 LANDO	VER ROAD	LANDOVE	R, MARYLAN	D 20785
			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caused the death.	Do not ente	r the mode of dying	g, such as cardiad	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPTICE	MIA					Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque						
h.	Examiner		Conventially list conditions	PNEUMO	NIA	+				
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nice of).					
	ocute nd trans	Examiner	that initiated events	С.						
Ö,	e exe ian a urial-	Ä	resulting in death) Last	Due to (or as a conseque	ince of):					
8760,	cate be executed physician and the burial-transit	dlcal		d						
9	death certific attending p	Mec	IF FEMALE:							
Вох	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	léath 3□E	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	ith 5 🗆	Other (specify)			World	Day 10ai
<u>С</u>	= > 3		Part II. Other significant conditions	t contribution to double but not mould	ing in the	daubina an an an	in David	220 Did tob		- N
S,	se un eq	by	RENAL	PALL URE	ang in the und	deriying cause give	en in Parti.			the cause of death?
Records,	w requir been s should	Completed	NEWAL .	FAILURE VAL ULCE,	0			10.10	S 20 NO 30F	Oriknown
ec	e law has b	nple	DUODER	VAL OCCE	K.			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
=		Co						perform 1 ☐ Yes 2	ed death? No 1 ☐ Yes	No
Vital	ysician: Th	Be	25. Was case referred to medical examiner?					th (Check only one)	
of	S S	2	1 ☐ Yes 2 No		R/Outpatient	3□ DOA Othe	er: 4 ☐ Nursing H		nce 6 Other (Spe	ocify)
ň		on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. ate of Injury 2 (Month, Day Year)	28b. Time of Injury	28c. Injury Work	(?	28d. Describe ho	w injury occurred	
Si	Attending r death. ector: After	cat	2 Accident investigati 3 Suicide 6 Could not	he			Yes 2 □ No			
Division	l or Atten after deatl Director: I in by the	ertification;	4 Homicide determine		ne, farm, stre	et, factory, office		28f. Location (Str City or Town,	eet and Number or R State)	ural Route Number,
	Hospital or 14 hours afte Funeral Dir tely filled in I	O	200 00 00 00 00 00 00 00 00 00 00 00 00	No. of the second secon						
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a, Certifier 1 Certifying f (Check only 2 Medical Ex-	Physician: To the best of my knowlearning: On the basis of examination and manner stated.	iedge, death on and/or inve	occurred at the time estigation, in my op	ne, date and place pinion, death occu	r, and due to the ca arred at the time, da	use(s) and manner a te and place, and du	s stated. to the cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of pertition	and mariner stated.		29c. License	number	20	d. Date signed (Mon	h. Dav. Year)
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Λ	(1)		Way			<u> </u>	1		0/10/00	<i>V</i> 3
K.	(4)		VENKAT. S.	o completed cause of death (Item 2)	23a) (Type, P	PATTS	KOAD	#307	CUNTON	MS
	Sta	to	31. Date filed (Month, Day, Year)							20735
	Registr	-	AUG 1 7 20	Registrar's Signatur	Spo	The same				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 5 28632 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:20 a 2005 August 12, Francis Patrick Dollymore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** M∏M 2□F 1925 Washington, 579-10-3909 29, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20895 3404 Farragut Avenue or Items 23a or Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married 1 Yes 20 No White Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced natural 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of College (1-4or 5+) I Hygiene. other than Elementary/Secondary (0-12) Liquor Control Management permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Importent: If Item 27 is marked other it
any injury or other treumatic event, its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Sullivan Patrick J. Dollymore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3404 Farragut Avenue, Kensington, MD 20895 Mary Lou Dollymore/ Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 2005 4 □ Donation 5 □ Other (Specify) Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes acuto Due to (or as a consequend Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit resulting in death) Last Due to (or as a consequence of) cal the Se esn ģ ed by the a

Physician /Medical **Examiner**

the Maryland

with

filed within 72 hours after death

Maryland 21215-0036

Baltimore.

To the Hospitel or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certific

Division of Vital Records, P.O. Box 68760,

within 24 hours e To the Funerel C completely filled 0+1

	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
		performed? death? 1 Yes 2 No
examiner?	Haspital: Other -	
1 ☐ Yes 2 💢 No	1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home	e 5 Residence 6 Other (Specify)
1 Natural 5 Pending	(Month, Day Year) Injury Work?	ld. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	It. Location (Street and Number or Rural Route Number, City or Town, State)
	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ZNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Hom: 4 Nursing

D0053887

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 12,2005

completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 M.D. Orlee Panitch

31. Date filed (Month, Day, Year) State 18 AUG Registrar

29b. Signature

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State
Registrar Amended items 4a, 4b, 26 per de rificate of Death wichd/8-18-905 10 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Lois Walker August 15, 2005 Duver 8:17 /Medical 4a. Facility Name (If not institution, give street and number)

Adventist

Shady Grove Memorial Hospital 4b. City, Town, or Location of Death Rockville 4c. County of Death **Examiner** Gaithersburg Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours 1 □ M 2**X** F Director 170-26-9551 77 10/19/1927 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 XYes 2 ☐ No Texas Completed by Funeral Director Hidalgo Mission 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 North Conway #596 78572 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. traumatic event, the Medical Evaniner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 12 Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George H. Walker Emma Friedline ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace Duyer/husband Department of Health a Important: If item 27 Is any injury or other trains 000. 2707 N. Conway #596, Mission, TX 78572 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 8/18/05 Hurlock, MD * 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 10 Cal /Medical Due to (or as a c) sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the al P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 EP/Outpatient P 1 Yes 2 No 1 Inpatient 5 Residence 6 Other (Specify, 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51980 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Brett Gamma 9901 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State AUG 1 8 2005 Registrar

		1 - State State Registrar	of Maryland / Depa Cea	artment of Health and I rtificate of Death	Mental Hygie	2005	28634
Physic /Medi		Decedent's Name (First, Middle, Last) Samuel H. Edmondson			2. Date of Death Month 08 16	Day Year 2005	3. Time of Death 1:30 P M
Examir		4a. Facility Name (If not institution, give street and r Fort Washington Health		4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince Go	
Funeral Director		5. Social Security Number 579-12-8016 6. Sex 1 № 1 № 1 № 1	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 06-02-19	9. Birth Wash	place (State or Foreig intry) Lington DC
Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Prince George	10c. City, Town or Lo S Upper Mar				10d. Inside City Limit Yes 2□N
with the A	Direct	10e. Street and Number 5605 South Marwood Blv	d apt 406	10f. Zip Code 20772		Citizen of What Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: It item 27 is marked other then "naturel", or Items 23a or 28a-f show many injury or other traumatic event. I'm Medical Exertile in the hilling at ance.	by Funeral Director	11. Marital Status 12. Was De Armed	cedent Ever in U.S. 13.1 Forces? 5 2 No	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White Specify.Blace	, etc.
nd within 72 hours af giene. er then "naturel", or	Completed by	15. Decedent's Education (Specify only highest grade complete: Elementary/Secondary (0-12) 54	16a, Dece	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) ator	king	c. Kind of Business/li	
id 2 should be filed th and Mental Hyg 27 is marked othe traumatic event.	To Be C	17. Father's Name (First, Middle, Last) Samuel Holt Edmondson,	Sr.		ne (First, Middle, Mai Frances W.		
and 2 shoutealth and Normal traumal		19a. Informant's Name/Relationship (Type, Print) Ruby Edmondson/Wife	5605	ng Address (Street and Number or Ru S. Marwood Blvd,	Upper Mari	lboro, MD	20772
oermit. Pages 1 ar Department of Hea mportant: It item any injury or othe		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Removal from 1 □ Donation 5 □ Other (Specify)	"" Chesapeak	e Crematory 08-	18-05 Be	Ltsville,	MD
permi Depa Impo any ir		21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications tha	Klard 65	2. Name and Address of FacilityStr 00 Allentown Rd.	Camp Sprir	ngs, MD 20	
cate be executed /Medical Examiner bhysician and the burial-transit the burial-transit	dical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	nary Artery Di	sease rdiovascular Dise	ase		Interval Between Onset and Death
The law requires that the death certificate to the lass been signed by the attending physic page 2 should be detached for use as the b	Physiclan/Medica	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy		23d. Date of deliv	ery Day Year
uires that the d i signed by the	þ	Part II. Dther significant conditions contributing to Perpherial Vascular Di	death but not resulting in the u	nderlying cause given in Part I.		co use contribute to	the cause of death?
The law requir ate has been si page 2 should	Completed	Seizure Disorder			24a. Was an autopsy performed	prior to co	opsy findings available mpletion of cause of
of a fittending Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be a	To Be	27. Manner of Death 28a. Dat	Inpatient 2 ER/Outpatien e of Injury 28b. Time of Injury Injury	t 3 DOA Cther: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in		f y)
or Attendeate after deate Director:	Certification;	3 Suicide 6 Could not be	ce of Injury - At home, farm, str Iding, etc. (Specify)		28f. Location (Stree City or Town, St	t and Number or Rur tate)	al Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	(Check only 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or in nner stated.	n occurred at the time, date and place vestigation, in my opinion, death occur	and due to the cause rred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
To the within 2 To the complete Me	29b. Signature and title of cepifier)	29c. License number	I	Date signed (Month,	Day, Year)	
41kg		30. Name and address of person who completed ca Edger Potter 1328 South	ern Avenue, S.		shington D	20032	
Sta Regist		AUG 1 8 2005	Registrar's Signature	why			

State of Maryland / Department of Health and Mental Hygiene Reg. 2.005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 27, 2005 10:40 P. M Edwards Licille /Medical Ac County of Death
Prince George's 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lanham Examiner Doctor's Comunity Hospital 7. Age (In yrs. last birthday) 82 yrs 5. Social Security Number 228–30–1870 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 31, 1923 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖸 F Director Virginia Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "naturei", or items 23a or 28a-f show Medical Examiner must be notified at Glenarden Maryland Prince George's 1 XXes 2 ☐ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. important: If item 27 is marked other than "naturel", or items 23a any injury or other traumatic event, the Medical Examinet must once. 20706 U.S.A. 7931 Dellwood Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Black ģ Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government (Retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Supervisor Navy Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Williams William Herbert Graves ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7931 Dellwood Avenue Glenarden, Maryland 20706 Mr. James R. Edwards (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cemetery August 3, 2005 Chelterham, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 elson ad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Essential Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit death certificate be executed Chronic Renal Failure years that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical years Hyperparathyroidism IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Severe Degenerative Joint Disease icete has been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo this After thi 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Funeral 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only within 2 To the F the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number August 16, 2005 MD31069 person who completed cause of death (Item 23a) (Type, Print) George H. BOne, M.D. 1100 Mercantile Lane Suite #135 Largo, MD 20774 AUG 1 7 2005 32. Registrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygien 200528636 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death **Physician** Month Year Nancy Ann Evers-Duggan August 13 2005 2:03 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □XE Director 220-56-2725 Yrs 1952 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumstic event, the Medical Examiner must be notified at Director 1√2 Yes 2 No Maryland Prince George Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7812 Lake Crest Drive items 23a 20770 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 3m 27 le marked other then "neturel", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working College (1-4or 5+) Elementary/Secondary (0-12) Manager U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Hudson Evers Mildred McManas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 8423 Brock Bridge Rd., Laurel, MD Katrina Sturgess-Durable POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If its
eny injury or o
once. ō 1 Burial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 8/17/05 Brentwood, MD 22. Name and Address of Facility
Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20772 23a. Part1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer of Cervix /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Causs (Disease or inju-that initiated events resulting in death) Last Respiratory Failure Due to (or as a consequence of): attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 🙀 No the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe Seizures 1 Yes 2 No 3 Probably 4 Unknown Completed Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No Division of Vital 1 ☐ Yes 2X No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 🛣 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medice! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0052075 30. Name and addra's of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive, #221, Laurel, MD Deep Kukreti, M.D. 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 8 2005 Registrar

		•	For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F			2005	28637
	Physici		1. Decedent's Name (First, Middle, L Vicki Darlene Eg					2. Date of Death Month August 12	Day Year 2005	3. Time of Death 6:40 p M
	/Medic Examin		4a. Facility Name (If not institution, g Holy Cross Hosp		per)	4b. City, Town, or Silver S	r Location of Death	,	4c. County of Death	1
	Funeral Director		5. Social Security Number 6. 220-60-0003 Usual Residence of Decedent	Sex 7. 1 □ M 25€ F	. Age (In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You June 05,		place (State or Foreign ntry)
	Maryland -f show	tor	10a. State 10b. County Maryland MONTGOM	IERY	10c. City, Town or L Silver Sp					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with tha	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
980	d within 72 hours after death with the Maryland Jene. I than "natural", or Items 23a or 28a-f show The Medical Esandrar must be rodiffed at	by Funeral	4524 Bennion Roa 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Forc	es? X No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S un, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race - Americ Black, White, Specify: White	etc.
21215-0036	within 72 ho iene. rthen "naturi the Medical i	Completed	15. Decedent's (Specify only highest g		(Give life.	edent's Usual Occup s kind of work done of DO NOT use retired smetologi	during most of wor f)	king	Cosmetolog	
Maryland 2	s 1 and 2 should be filed if Health and Mental Hygis item 27 le marked other other treumatic event, II	To Be C	17. Father's Name (First, Middle, La. Arthur Byrd Fre			3.m. 5 5 2 5 8 -	18. Mother's Nan	ne (First, Middle, Ma ne Oliver		5.V
Mary	d 2 sho th and h	2	19a. Informant's Name/Relationship Mr John Pappas-H						ity or Town, State, Zip	Code)
ds.	Pages 1 and 2 lent of Health int: If item 27 I		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from St	20b. Place of Disp	osition (Name of matory or other place	ce)		Location - City or To	
Balti	permit. Pages 1 Department of H Importent: If ite any injury of once.		21. Signature of Flyndral Sprvide Lic	ensee	. 2	2. Name and Addres	ss of Facility		emation Ce le MD 2085	
	Pnysician	6 JI	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		used the death. Do not en ching. ble ocute pu	ter the mode of dyin	g, such as cardiad	or respiratory arrest		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Metas Dua to (or	r as a consequence of): tatic Inflar r as a consequence of): r as a consequence of):	nmatory B	reast Car	ncer		
O. Box 6	the death certify the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	nt at time of death 5	□Ectopic pregnancy □ Other (specify)	,		23d. Date of delive	ery Day Year
rds, P.	signe d be	by	Part II. Other significant conditions Hypertention	contributing to dea	ath but not resulting in the t	underlying cause gre	en in Part I.		co use contribute to the	
Vital Records	The law requate has been page 2 shoul	Completed	Smoking (Nicotein		on)			24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
Vita	iclen: certific rector,	o Be C	Depression/Anxcia 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hoepital	patient 2 SEP/Outpatie	at 30 DOA Oth		th_(Check only one)	e 6 □Other (Specif	
ion of		-	27. Manner of Death 1 Tanatural 5 Pending 2 Accident investigat	28a. Date of (Month)		of 28c. Injun Wor	y at	28d. Describe how		y)
Division	or A after Dire in b	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place 0	of Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura state)	al Route Number,
	H T T T S	edical	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the bas aminer: On the bas and manne	pest of my knowledge, dea sis of examination and/or in ar stated.	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	. 10	~	29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
•	15		30. Name and address of person wh	o completed cause	of death (Item 23a) (Type	00D41	752		08/12/200	5
	Sta	ite.	Bergit Schoellma 31. Date filed (Month, Day, Year)	32 Re			Silver S _I	oring, Mar	yland 2091	.0
	Regist		AUG 18 2	005	in Is Apr	will				

			1- State of Maryla	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death	lental Hygie Reg.	ⁿ 2005	28638
			Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Mohammedaddel		Elmuhdd	iy	87 15	2005 Pear	21:5 8 p ^M
7	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death	
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Silver If Under 1 Year	_		Iontgomer	
	Funeral Director		unavailable 152 M 2□F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
	D		Usual Residence of Decedent				8/15/20	205 Mary	/land
	anylan show	_		ity, Town or Lo 1ver	Spring			1	10d. Inside City Limits
	Ba-fs	ecto		1761					1 ☐ Yes 2 No
	with t	Funeral Director	10e. Street and Number 4500 Randolph Rd.		10f. Zip Code 20906	;	_	Citizen of What Cour	ntry ?
	death	era	11. Marital Status 12. Was Decedent Ever in	J.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	
336	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28a-f show ther, the Marikal Examinat much be mulified at	ρ	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2KI No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White, Specify: Whi	
20	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation	166	b. Kind of Business/In	dustry
21	ithin Sen	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done of DO NOT use retired)	9		
2	fygier her th		0 17. Father's Name (<i>First, Middle, Last</i>)	uner	nployed	10 Mathada Nama	(First, Middle, Mai	rione	
anc	ntal Hed of	Be c	Morewan Elmuhddiy			Abir	Mazrab	oen sumame)	
Maryland 21215-0036	should nd Me mark mark	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a			ity or Town, State, Zip	Code)
Š	alth al		Morewan Elmuhddiy - Father	4500	Randolp	h Rd., W	heaton,	Md. 2090	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then. natural; or items 23a or 28a-f show among righty or other treumatic event, the Medical Examinatinal be indiffied at once.		4 1770 - 14 - 0 17 O - 14 - 14 - 14 - 14 - 14 - 14 - 14 -	cemetery, crei	osition (Name of matory or other place ton Nati	θ)		. Location - City or To uitland,	
Baltii	permit. F Departmo Importer any injur		21. Signature of Fineral Service Lifesee		2. Name and Addres		niversal N.W. Wa	Mortua ash. D.C.	
			23a. Part1. Enter the disease, or complications that caused the desphock, or heart failure. List only one cause on each line.				or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	Premat	rity.			Onset and Death
4	/Medical		resulting in death) a. Due to (or as a conse	quence of):					
	Examiner		Sequentially list conditions, b.						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate trust. Ent. In Julying Cause (Disease or injury	quence of):					
	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)	***************************************		23d. Date of delive Month	ery Day Year
, P.O.	that i	y Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
rds	quires in sign	ed by					1 ☐ Yes	2 No 3 Prob	pably 4 Unknown
Records,	law requirens been sistemated to a should to	Completed					24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
H H	sician: The law certificate has t irector, page 2 s						performed 1 ☐ Yes 2 ☐		2 □ No
Vital	Physician: r this certificaral director, i	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of Death			
ō	Phy rald	2	TEL 195 25XNO TEL INDAMENT 21	ER/Outpatier 28b. Time o	II 3 DOA	4 Nursing Hor	ne 5 🗌 Residence 28d. Describe how i	e 6 ☐Other (Specification of the following of the follow	(y)
o	Attending r death. ector: After by the fune	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Worl	k? Yes 2 ∐No		,,	
Division	Attendi r death. ector: A by the fu	Certification:	3 Suicide 6 Could not be	home, farm, sti	reet, factory, office			t and Number or Rura	al Route Number,
Ö	s afte	Cert	4 Homicide Soldmined building, etc. (Spec	ary)			City or Town, S	rate)	
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)						
	To the within To the comp	Ň	29b. Signature and title of certifier		29c. License P189		29d.	Date signed (Month,	Day, Year)
	1		I Imakplilled	7_	F109	1 .		8/15/0	,
-	•		30. Name and address of person who completed cause of death (Ite					_	
	-		Saimah Talukder 1500 Fore			Silver	Spring,	Md. 2091	0
	Sta Registi		31. Date filed (Month, Day, Year) AUG 18 2005 32:Registrar's Sign	H. So	well				

040		1- For Unpend Item 23	State of Maryla a,27,28a-f	nd/Depa er mee	artment of	Health and 2 <u>6 e</u> 2th tas	Mental Hyg s	giene 005	28639
Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Last) Warren E. Edwall, 4a. Facility Name (If not institution, give st	Jr.			or Location of Dea	2. Date of Dea Month August		3. Time of Death 05 1558 M
Funeral Director		Suburban Hospital 5. Social Security Number 214-52-2801 Usual Residence of Decedent	7. Age (In yrs	s. last birthday) 2 Yrs.	Bethe If Under 1 Yea Months Day	r If Under 24 Hr		Montgor (1) Year) 9.1 953 Was	nery Birthplace (State or Foreign Country) Shington, DC
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show ery injury or other traumatic event, the Madical Exercipal marked by neitified at once.	ector	10a. State 10b. County MD Montgomery 10e. Street and Number		ckville			1	log. Citizen of What	10d. Inside City Limits 1 X Yes 2 □ No
ler death with Items 23a or	by Funeral Director	550 College Parkwa	2. Was Decedent Ever in Armed Forces? 1 Yes 2 (A)No	U.S. 13.	20850		(Specify Yes or No- erto Rican, etc.)	U.S.A.	merican Indian, /hite, etc.
in 72 hours af "natural", or tedical Exer-	Completed by F	3 Widowed 4 Divorced 15. Decedent's Educt (Specify only highest grade)	If Yes, Give Year or Dates: Ition completed)	16a. Dece	1 ☐ Yes 2 ☒ No dent's Usual Occ kind of work don DO NOT use retii	upation e during most of w	vorking	Specify: W	
d be filed with intal Hygiene. ded other than c event, the M	Be	12 17. Father's Name (First, Middle, Last) Warren E. Edwall.	College (1-4or 5+)		None	18. Mother's N	ame (First, Middle,	•	
l and 2 should lealth and Me im 27 is mark her traumatic	J.	19a. Informant's Name/Relationship (Typ Warren E. Edwall, S	e. <i>Print)</i> rFather	2090	North At	and Number or F	Rural Route Number	r, City or Town, State Cocoa Be	ach, FL 3293
mit. Pages 1 pertment of H portant: if ite y injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Jign Tre of Fine HI Service Licensee	Ft	. Linco		tory 08/2		rentwood,	
EBES S		23a. Part1. Enter the disease, or complic shock, or heart failule. List only one Immediate Cause (Final	_	10 ath. Do not ent	40 Rockv	ille Pik	e, Rockvi	lle, Mary	Approximate Interval Between Onset and Death
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un: The law r lificete hes be or, page 2 sh	e Completed	25. Was case referred to medical				26 Place of D	24a. Was a autops perform 1 Yes	med? prior death 2 No 1 1 1	autopsy findings available to completion of cause of i? 'es 2 No
Attending Physicia r death. ector: Atter this cert by the funeral direct	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury Fournth, Day Year) 8-20-05 28e. Place of Injury - At	28b. Time o Found 3:28 home, farm, sti	f 28c. In	ther: 4 ☐ Nursing ury at ork? ☐ Yes 2 🛣 No	Home 5 Reside 28d. Describe he Subject Ambient 28f. Location (S	ence 6 Other (Sow injury occurred Exposed Temperations of the second se	To High Ires
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Certi	29a. Certifier 1 Certifying Physi	building, etc. (Spec Scene Cian: To the best of my ker: On the basis of examinating and manager stream	nowledge, deat	h occurred at the vestigation, in my	time, date and place opinion, death occ	Democracy ce, and due to the c	n. State Old Go y Blvd., I ause(s) and manner late and place, and o	Bethesda, Md as stated.
To the To the comple	Med	29b. Signature and title of certifier		,	O	nse number		and Date signed (Mo	
Sta	ite ar	30. Name and address of person who con ZAN / LLCAH 31. Date filed (Month, Day, Year) AUG 29 200	A L J 32 Registrar's Sig		111	Penn Stre	eet Balti	lmore, Mar	ryland 21201

		1 - For State RegistrarAMEND #23	a PER PHYS	CHD DB 8/18/05	Cen	rtment of I tificate of	Death		Reg. N.	2005	2864
Physic	ian	Decedent's Name (First, Middle, Sherman	Last)	Fro	eemar	2		2. Date of De Month	Day	Year	3. Time of Death
/Medi	ical	4a. Facility Name (If not institution,	ain street and number		emai	4b. City, Town, o	or Logation of Do	AUGUST		2005 County of Deat	6:00 A
Exami	ner	CIVISTA MEDIC		,		LAPLAT		aut		CHARLES	
Funeral			6. Sex 7. A	ge (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bir	th	9 Birtl	hplace (State or Forei
Director		226-16-1891	X□M 2□F	84	Yrs.	WOITING Days	Hours	Aug. 2	5,19	20 Vii	ginia
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation					10d. Inside City Limi
ter death with the Maryland items 23s or 28e-1 show instribust be natified at	to	Maryland Cha	rles	Nan	njemo	ν					1 □Yes 🗶 💢 N
or 28e	Funeral Director	10e. Street and Number		11011	- J OC	10f. Zip Code		1	10g. Citiz	en of What Co	untry?
th wit	aiD	8780 Riversid	e Road			2066	2		U	.S.A.	
r dea	ner	11. Marital Status	12. Was Decedent Armed Forces	?	13. W	as Decedent of H	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 1	4. Race - Amer Black, White	
hours after turai, or ite	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2√2 If Yes, Give Year or Dates:] No		☐Yes 2☐No				Specify:	nite
2 hour		15. Decedent	1		6a. Decede	ent's Usual Occup	pation		16b. Kir	NV I	
within 72 ene. then "net by Medic	Completed	(Specify only highest Elementary/Secondary (0-12)			(Give k	kind of work done OO NOT use retire	during most of v	working			, industry
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		A Donation 5 Other (So	3 ⊟Hemoval from State	Nani	etery, crem	z Banti	~Augus	rch	05	- 4	. M1
artme ortan injur		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecify)	Nanj	j emos	Bapti Name and Addre	st cnu	rch	Na Na	njemoy	, Maryl
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DHMH 17 Rev 1/2001

State Registrar SONG C. CHON, MD CENN
31. Date filed (Month, Day, Year)

AUG 1 8 2005

CENNA MEDICAL CENTER 7C POST OFFICE RD. WALDORF, MD 20602

	d1		For			l / Depa	rtment of H	ealth a		ental Hy	giene	egible.		
			1 - State Ragistrar			Cer	tificate of L	Death				2005		
	Physici	an	Decedent's Name (First, Middle, NATIONAL TOTAL		MODSE.		TAT TAM (TTT	ar)		2. Date of Dea Month August	Day	Year	3. Time of	
	/Medic		MICHAEI 4a. Facility Name (If not institution,		MORY		FLETCH 4b. City, Town, or		of Death	August		County of Dea		P "
	Examin	er	4119 Federal Hi	_			Jarretts					arford		
	Funeral	0.1	5. Social Security Number	6. Sex 7. A	ge (In yrs. las		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birtl (Month, Da)	h /, Year)	9. Bir	thplace (State or	r Foreign
	Director		216-96-6292	1 ∑ M 2□F	41	Yrs.	Midital Suys	110013		5/12/	1964	+ Ma	arylan	d
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside Cit	ty Limits
	Mary In-f	tor	MD. Han	rford			Jarre	etts	vill	e			1 🗆 Yes	2 X No
	th the	Director	10e. Street and Number		-1		10f. Zip Code				-	en of What Co	•	
	ath w			ral Hill					084				State	S
	item Item	by Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces	?	. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto P	cify Yes or No- Rican, etc.)	14	 Race - Ame Black, White 		
200	hours after death with the Maryland turet', or Iteme 23a or 28e-f ahow al Exercination in collised at		3 Widowed 4 Divorced	lf Yes 2 M If Yes, Give Year or Dates:		1	Yes 2 No	Specify:			s	Specify:	White	
9500-61212		Completed	15. Decedent's (Specify only highest	s Education grade completed)		16a. Deced	lent's Usual Occupa	ation fu <i>ring</i> most	t of workin	la l	16b. Kind	d of Business	/Industry	
7	within 72 ene. than "nei	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done do DO NOT use retired, pet Ins					Comi	peting	
	filed v Hygie other i	ပိ	17. Father's Name (First, Middle, L	ast)		vai	ber TH2			(First, Middle,	Maiden S		bening	
Maryland	Mental Mental Mad c	To Be	Elmer	Roy		Flet	cher	P	risc	illa	Ir	ene	Richa	ards
a	and N		19a. Informant's Name/Relationsh				g Address (Street a				r, City or	Town, State,	Zip Code) 2	1084
	s 1 and 2 if Health item 27 other tr		Priscilla Fle	etcher/Mo			Federa.			Commercial configuration			ville,	Md.
Baitimore,	. Peges 1 tment of H tant; if its jury or ot		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from State			sition (Name of natory or other place			ate .		ation - City or		
			4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	_ / - / / / - / - / - / - / - /	Car	roll	Cremat:	lon of Eacility						
n	Depending Dependent Importations and Injury		MI Blue	Warn Fre	# I		E.G. Ku		00	rrett	SV11	Te, I	Maryla	na
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause	d the death.	Do not ente	er the mode of dying	, such as	cardiac or	respiratory ar	rest,	. 110111	Approximate Interval Bety	9
	Physician		Immediate Cause (Final disease or condition	HAN	2100								Onset and D	Death
	/Medical Examiner		resulting in death)	Due to (or a	a constitue	ence of):								
	£ t	-	Sequentially list conditions,	b. — Due to (or as	a conseque	ance of):					_			
H,	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 (0) 43	a conseque	nice oi).								
ה ב	sician end burial-transit		that initiated events resulting in death) Last	Due to (or as	s a conseque	ence of):								
3/60,	2 2 0	Icai		d			· · · · · ·							
χο ×	death certificate e attending phys d for use es the	Med	IF FEMALE:	220 Huga sutame										
ž	eath c attend for us	slan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	leath 3 🗆	Ectopic pregnancy Other (specify)				23	d. Date of de Month		'ear
j	the y th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	it tallo of dod	5	Cities (specify)							
λ J	requires thet leen signed b hould be deta	by P	Part II. Other significant condition	s contributing to death I	but not result	ting in the ur	nderlying cause give	n in Part I.		23e. Did to	bacco use	contribute to	o the cause of de	eath?
ä	equire en sig ould b									1 🗆 Y	es 2	(vo 3□P	robably 4 □U	Inknown
Hecord	e law r hes be je 2 sh	Completed								24a. Was a autop	sy	prior to	utopsy findings a completion of ca	available ause of
	The ele				-					1 perfor	med? 2□No	death?	2 □ No	
Vital		o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:		210	Othe	-		(Check only of		Ar	COOD	
ō	iding Phys th. After this funeral di		27. Manner of Death	1 Inpati	urv 2	P/Outpatien 28b. Time of	28c, Injury Work	4 🗀 NU	2	ie 5 ☐ Resid 8d. Describe h	ow injury	occurred		
Uivision	Attanding r death. actor: After by the fune	Certification:	1 □Natural 5 □ Pending 2 □ Accident investiga	ation August 18	12005 F	and 1		res 2 🗐	No S	ubject	har	ged.	seff	
<u> </u>	2 0 -	rtific	3 Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In	iury - At hom tc. (Specify)	e, farm, stre	eet, factory, office		2	8f. Location (S City or Tow	treet and n, State)	Number or R	ural Route Numb	ber,
\supset	pital o		Continue 15 Continue	Dhusiaian T. d	Lon					1119 Fed	JON	LEUSUI		
	To the Hospital or Attan within 24 hours effer deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best xaminer: On the basis of and manner s	of examination	edge, death on and/or inv	occurred at the tim restigation, in my op	e, date and inion, deat	d place, a th occurre	nd due to the o d at the time, o	ause(s) a late and p	nd manner as lace, and due	s stated. e to the cause(s))
	Mithin To the	Me	29b. Signature and title of certifier				29c. License	number		2	29d. Date	signed (Mont	h, Day, Year)	
,			1 Aorshow	Jeel	run)	OCME				4110119	t 19,	2005	
	10	1	30. Name and address of perant w	no completed care of	death (Item 2	23a) (Type, I	Print)	1.000						
	Ψ		31. Date filed (Month, Day, Year)	elnherg	rar's Signatu	7	111 PEnn	Stree	et, E	altimor	ce Ma	ryland	1 21201	
	Sta Registr		SEP 0 1	2005	rar's Signatu	Rose	actil .							
DH	MH 17 Rev 1/2	-	OF! AT	TOO I THEN	and the	1000								

ORIGINAL

			1 - For State Registrar	State of Ma	ryland	-	artmen rtificate					giene Reg. N20	05	28642
ı	Physici /Medic	al	Decedent's Name (First, Middle, Las. Ann	Marı	e			hery		-(D - + 1	2. Date of Dea Month August	Day 13,200		3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give Kris Leigh Assis					mbri.	Location o	of Death			ty of Death	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last	birthday)	If Under	1 Year	If Under		8. Date of Birt (Month, Day			rundel place (State or Foreign untry)
	Director		003-12-7744	□ M 2 XX	94	Yrs.	Months	Days	Hours	Min.	June 11	,1911	Mai	ne
	land Sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	Mary First	tor	MD Anne Ar	undel		Gam	brill	s						1 ☐ Yes 2X No
	or 28e	Jirec	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	untry?
	ath wi	rai	947 School Lane						054				SA	
_	72 hours after death with the Maryland natural', or tterns 23a or 28e-f show lical Examination that be mailted at	Funerai Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ender Armed Forces?		13.	Was Oeceo	ent of His ify Cubar	spanic Ori n, Mexican	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	14. Ra	ice - Amer ack, White	rican Indian, o, etc.
3-003p	al', or	ρχ	3 XWidowed 4 ☐ Divorced	1 □ Yes 2 □ No If Yes, GiveXX Year or Dates:			1□Yes 2	2 ANO	Specify:			Spec	ity:	White
	72 hc	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	1	6a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion uring mos	t of worki	ng	16b. Kind of	Business/I	ndustry
7 7	within lene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	-)		omema					Own :	Uomo	
	Hygother other ent,	Be Co	17. Father's Name (First, Middle, Last)	<u>-</u>			ome ma		18. Mothe	er's Name	(First, Middle,			
/land	2 should be and Mental le marked craumatic ever	To B	Unknown	Plourde					Unl	known	1			
Mar	s 1 and 2 should f Health and Mer item 27 le marke other traumatic		19a. Informant's Name/Relationship (T				-				l Route Numbe			
a)	s 1 and of Health item 27 other tr		Margaret Gallant 20a. Method of Disposition	(POA)	20b. Place	e of Dispo	sition (Nan	e of			Westmi	nster,		
altimor	Pages ent of nt: If if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				n <i>atory</i> or o		1	9-2-	2005	Arling		
<u>a</u>	permit. Pages Department of H Importent: If ite eny injury or of		21. Signature of Funeral Service Licen-		1		2. Name an	d Address	s of Facilit	v	Home, P			
מ	#9 # 9		177- 7.	m			12 R	idge.	ly Av	enue	, Annap	olis,	MD 21	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	Э.					•		rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Cereb Due to (or as a	consequen	ras (rila	- 1	Acci	a.e.	nt			
	Examiner		Sequentially list conditions	HYPI	GRT	BN	2100	ſ						
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequen	ce of):								
	xecut	хап	that initiated events resulting in death) Last	c Due to (or as a	consequen	ce of):								
8/60	ysicier e buria	dicai E		d										
٥	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Medi	IF FEMALE:											
X Q Q	ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal de	ath 3□	Ectopic pr						ate of deliv	very Day Year
j.	the de y the a	ysic	1 ☐ Yes 2 월 No 9 ☐ Unknown	9□ Unknown	ime or deatr	1 5	Other (sp	эспу)						
νυ. Τ	s that gned b	by Pł	Part II. Other significant conditions co	entributing to death but	t not resultin	g in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use cor	ntribute to	the cause of death?
g	w require been sig should t										1 🗆 Y	es 2√2 No	3 Pro	bably 4 Unknown
Hecords	elawi hasb	Completed									24a. Was a autop perfor	sy	Were autoprior to co death?	opsy findings available omptetion of cause of
VITAL	sicien: The law s certificate has t lirector, page 2 s	e Co	25. Was case referred to medical								1 Yes	2 <mark>X</mark> No	1 Yes	26 No
	Physicien: r this certific ral director,	o B	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/	/Outpatier	it 3□ DO	A Othe			<i>(Check</i> on <i>ly</i> or ne 5 ☐ Resid		her (Speci	in Assisted Livin
n or	ding Phys	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28	b. Time of	2	Bc. Injury Work			28d. Describe h			77,125,131,131
DIVISION	ttendi death.	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ny - At home	form ate	M doctors		'es 2 □ l		Of Location (C	traat on d Alum	bar or Pur	al Route Number,
2	after after I Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	, iaiii, sti	eet, lactory	, onice		2	City or Tow		ber or nur	ai nodie Namber,
	To the Hospital or Attending Privithin 24 hours after death. To the Funerel Director: After the completely filled in by the funera	ledicai C	29a. Certifier 1 Certifying Phy	sicien: To the best of iner: On the basis of e	my knowled	dge, death	occurred a	at the time	e, date and	d place, a	and due to the o	ause(s) and m	anner as s	stated.
	the H the F the F mplete	Medi	one) 29b. Signature and title of certifier	and manner state	ed.			License		occurre		29d. Date sign		
	Twin o		250. Signature and interior continer),,,,,,	7 /	an	230	7	513	591		^		
			30. Name and address of person who o	completed cause of dea					^		4	TUJUS	1 17	MD210dd
			K. Ambalavana	784 €. Registrar			cool R	000	9,10	23	ale	n Bur	nie	MOZIOd
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 2005	AND THE RESERVE OF THE PERSON NAMED IN COLUMN TO SERVE OF	S Signature	As	de la							

DHMH 17 Rev 1/2001

			For State Registrer	State of Marylan		artment of F			giene Reg. No. 200	5 28643		
	Physici /Medic		Decedent's Name (First, Middle, Last) William Joseph	Fedeli				2. Date of Dea Month August	Day Ye 12, 2005	ar 8:09 P M		
	Examin		4a. Facility Name (If not institution, give st Suburban Hospita	L		4b. City, Town, o	đa		4c. County of D	Death Omery		
	Funeral Director		5. Social Security Number 6. Sex 182-09-0815 153 Usual Residence of Decedent	7. Age (In yrs. 95	Ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	Birthplace (State or Foreign Country) Pennsylvania		
	e Maryland ta-f show littied at	ctor	10a. State 10b. County Maryland Montgome		y, Town <i>o</i> r Lo nevy Ch					10d. Inside City Limits 1 ☐ Yes 2 No		
	th with th	al Dire	10e. Street and Number 5600 Wisconsin Ave	enue, #206		10f. Zip Code 20815			10g. Citizen of What USA			
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No WW] If Yes, Give Year or Dates: Kon	I &	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. hite		
Baltimore, Maryland 21215-0036	within 72 hc ene. than "natur he Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) 5+	(Give life. i	dent's Usual Occup kind of work done DO NOT use retired Chitect	ation during most of wo	orking	16b. Kind of Busine			
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Benedetto Fedeli	J+	ALC	SHILECT		me (First, Middle, a Rossi	Maiden Sumame)	cture		
Mary	ind 2 sho alth and A 27 is ma er trauma		19a. informant's Name/Relationship (Type Richard Caporiccio	•					or, City or Town, Star field, Vi	rginia 22150		
imore,	Pages 1 a ment of Her ant: If item ury or othe		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)	moval from State	emetery, crer	sition (<i>Nam</i> e of matory or other place National Ce		Ctober 2 2005		or Town, State		
Balt Balt	permit. Departi Importi any inj		21. Signature of Funeral Service/Licensed	Cerlo	50	00 Univer	sity Blv	d, W, Si		ng, MD 20901		
8760,	death certificate be executed //Medical Examiner e attending physician and of for use as the burial-transit	dlcal Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Multiorgan F Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of): /ascula		e, Sever	e		Interval Between Onset and Death		
.O. Box 6	the death certify the attending ched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year		
ecords, P.	sign d be	by	Part II. Other significent conditions cont Pneumonia	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown		
Œ	The law ate has b	Completed						24a. Was autop perfo 1 □ Yes	sy prior rmed? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\text{No} \)		
n of Vital	ding Physician: Th h. After this certificate funeral director, pat	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√√√0 27. Manner of Death 1√√2 Natural 5 ☐ Pending	spital: 1½ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		er: 4 🗌 Nursing I		ne) lence 6 □Other (5 now injury occurred	Specify)		
Division	eat or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	M 1 🗆	Yes 2 □ No		28f. Location (Street and Number or Rural Route Number City or Town, State)			
	ne Hospital or Att n 24 hours after de ne Funeral Direct bletely filled in by t	edical C	29a. Certifier (Check only one) 2 Certifying Physical Exemination (Check only one)	cien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)		
}	To the within 2	Me	29b. Signature and title of certifier			29c. Licens	e number 2347		29d. Date signed (M Augus	onth. Day, Year) t 13, 2005		
	(0.		30. Name and address of person who cor Marjorie Faith Da		8600 0	old George	etown Ro	ad, Beth	esđa, MD :	20814		
	Sta Regist		31. Date filed (Month, Day, Year) AUG 18 20	32. Negistrar's Signa	iture A	edi						

	_	For State Registrar	State of Marylan	•			ealth a Death	nd M	R	eg. No.	2005	
Physicia /Medic	al .	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s	traet and number)		4b. City	Town or	Location of	Death	2. Date of Dea Month	Day	Year	3. Time of Death
Examino Funeral Director		5. Social Security Number 6. Sex	e_	last birthday) Yrs.	2	or 1 Year	If Under 2		8. Date of Birth (Month, Day SEPT • I	Cr	21/201	
e Maryland 8a-f ahow ulffred at	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOMER		y, Town or Lo	cation							10d. Inside City Lim 1∑ Yes 2 □
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23s or 28s-f show avent, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number 6111 MONTROSE ROAD 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	APT . 620 12. Was Decedent Ever in U Armed Forces? 1 Yes, 20 No If Yes, Give Year or Dates:					in? (Spe Puerto	ecify Yes or No- Rican, etc.)	U	sen of What Co S A . 14. Race - Ame Black, White Specify:	rican Indian,
within 72 ene. then "na	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L MERCH	kind of w		during most	of worki		16b. Ki	nd of Business/	Industry
Mal yialla A	To Be C	17. Father's Name (First, Middle, Last) JACOB 19a. Informant's Name/Relationship (Ty	KUPER	10h Mailin	ag Addror	es (Stroot	ETHE	EL	(First, Middle,	(UNKNOWN	
es 1 and 2 and 2 and 1 trem 27 is		SYLVIA COHEN/DAUGH 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Cremation 3	ITER 20b. F	1021 Place of Dispo	CHIS sition (Na natory or	WELL ame of other place	LANE,	SI	LVER SP	RING		901
permit. Pages 1 ar Department of Hea Important: If Item any Injury people once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	BET Hottlemer	12-11	Name a NZAN 70 F	SKY-	SS of Facility GOLDBE ILLE I	ERG I	MEMORIAI , ROCKV	L CH	HINGTON APELS, MD 20	INC.
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		Falu		de of dyin	g, such as c	ardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
are be executed ysticien and he burial-transit	Ical Examiner	Sequentially list conditions, any leasing immediate cause. Enter Underlying Cause (Disease or injury that indicated events resulting in death) Last	Due to (or as a consequence)									
the death certifical y the attending phytched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3	Ectopic	oregnancy specify)					23d. Date of del Month	ivery Day Year
d b	by	Part II. Other significant conditions con	ntributing to death but not res								_	the cause of death?
The less age	Completed	Danation							24a. Was a autop: perfor 1 \(\subseteq \text{Yes} \)	sy med?	prior to death?	topsy findings availa completion of cause 2 No
ng Pl	lon: To Be	27. Manner of Death 1-Natural 5 Pending	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injur Wor	er: 46 Nur y at k?	sing Hor	me 5 Residence only or me 5 Residence on the control of the contro	ence (cify)
To the Hospital or Attending within 24 hours after death of the Funantal Director: After spimpletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str v)			Yes 2 □N		28f. Location (S City or Tow			ral Route Number,
To the Hospital within 24 hours a To the Funeral spmpletely filled	Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	vestigatio	n, in my o	pinion, deatl	place, a	ed at the time, o	ate and	place, and due	to the cause(s)
55)	29b. Signature and title of certifier 30. Name and address of person who co	Dily mo	n 23a) (Tunc	13		166 0			2/	e signed (Monti	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign						20- 2	5	(Inhos	2202

State of Maryland / Department of Health and Mental Hygiene 2005 28645 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 14, BEATRICE AUGUST 6:30 P ETTA FULTON 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct.1,1913 9. Birthplace (State or Foreign Country) New York 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 🛣 F 91 Days Hours Yrs. **Director** 070-20-8377 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eracular Install be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Director Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13801 Wagon Way 20906 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: <u>ک</u> 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Cashier Department Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Murphy Lula Davis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 er) 13801 Wagon Way, Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) Beatrice Alexander (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c Location - City or Town State Description 2 Cremation 3 Removal from State 8/19/05 Beechwood City Cem 4 □Donation 5 □ Other (Specify) New Rochelle, NY 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service License 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Status Epilepticus week /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed Diabetes Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 No Minknown 1 Yes Coronary Artery Disease Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension page 2 autopsy performed? 2X No Dementia 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 1 🖳 Inpatient funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1X Natural 5 Pending 1 Tes investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funerel The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Alun, M. D 00057630 Modella Aug. 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 Anuradha Arun 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 18 AUG Registrar

			1 - State Registrar	State of Maryland	/ Departme	ent of Health and ate of Death	l Mental Hy	giene2 (05	28646
		-11	Decedent's Name (First, Middle, Last) _ ;			2. Date of De	ath		3. Time of Death
	Physici		Marlo F	yaene Fle.	ming.	5R.	Month	Day	05	HAMM
	/Medio Examin		4a. Facility Name (If not institution, give	-1-1-0		ty, Town, or Location of De	ath		y of Death	
			213 Morris 51	-	FR	2uit/AND		W	Com	, CO
	Funeral		Social Security Number 6. Se		Month	der 1 Year If Under 24 H	rs. 8. Date of Bi	th av. Year)	9. Birthp	place (State or Foreign
	Director		JJX-86-617	M 20F 51	Yrs.			4-53		PA
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c, City, 7	Fown or Location		-			IOd. Inside City Limits
	f sho	ច	MD Wican		Ruit /	2m 1d				1 Yes 2 □ No
	28a-	Director	10e. Street and Number	11.00		Zip Code		10g. Citizen of	What Cou	ntrv?
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	death with the Maryland ms 23s or 28s-f show rmust by notiling at	by Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was De	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No	o- 14. Ra	ce - Ameri	
S	or ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No			erto Rican, etc.)		ack, White,	etc.
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5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Decedent's U	sual Occupation work done during most of v	vorking	16b. Kind of I	Business/In	dustry
121	within ene. than *	Idu	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. DO NO	Conver		1		2 - 1 11
121	filed withi Hyglene. other than		17. Father's Name (First, Middle, Last)		1 Kut		lame (First, Middle			e7762
Maryland	Mental H Marked of	Be		Flo :		Z . /		, Maidell Sujila	. 12	
Ž	d Me d Me mark matlo	7	19a. Informant's Name/Relationship (T	Fleming	10b Mailing Adds	ess (Street and Number or	Pural Bouta Numb	or City or Tour	State 7in	Code
Ma	d 2 sith and 17 is traus			ing father	40 - 4		FRILL HA	,	1, State, Zij	21871
é,	1 an Heal Iem 2		20a. Method of Disposition	20b. Plac	e of Disposition (/	Vame of	Date	20c. Location	- City or To	own, State
altimore,	permit. Pages i and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglens in the Marylan Bepartment of Health and Mental Hyglens in attural, or flems 23a or 28a-f show any injury or other traumatic event, the Mudical Exam are must be notified at once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	demoval from State	Hono Ce		24-05	Ede	~ n1	Ω
Ħ			21. Signature of Funeral Service Licens			and Address of Facility	2100		1, 1-1	
B	one con		Priscill	a Kninds	957	W. Isabelli	NO 5	4801		
	•		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.			liac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CANO	ERR OF	HYPOPHA.	0414			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequer						
	Examiner		Sequentially list conditions		GRESPIRA:	TORY ARR	E57.			
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer						
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60,	be e) ician buria	a E				Hypop H.	ADVNY			
68760,	ficate be executed physician and is the burial-transit	edicai	•	d	VAN UT	77 97 67 11	77-770			
×		/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	y			23d. D	ate of deliv	erv
Box	death atter	ciar	in the past 12 months?	1 Live birth 2 Fetal de 4 Pregnant at time of deat		pregnancy (specify)			onth	Day Year
P.O.	The law requires that the death certiste has been signed by the attending bage 2 should be detached for use a	Physician/M	9 Unknown	9□Unknown						
σ, σ	res that igned to be deti	by P	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the underlyin	g cause given in Part I.	23e. Did	tobacco use coi	ntribute to t	he cause of death?
Records,	w require been sig should b						1	Yes 2 No	3 Prol	oably 4 Unknown
CO	aw requisible been 2 should	Completed					24a. Wa	an 24b	. Were auto	ppsy findings available
R	sician: The law s certificate has b lirector, page 2 s	Ho					- auto perf 1 ☐ Yes	ormed?	death?	mpletion of cause of
ital		0	25. Was case referred to medical			26. Place of [Death (Check only			
of Vital	Physician: this certifica ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3	DOA Other: 4 Nursing	Home 5 Res	idence 6 🗆 O	her (Specia	5)
	ding PI		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	3b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occu	irred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		М	1 Yes 2 No				
Division	or Atl	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fac	tory, office		(Street and Nun wn, State)	iber or Run	al Route Number,
	pltal ours a eral I		29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	adas dasth secure	ad at the time, date and pli	and due to the	causals) and m	20001 20 0	tatad
	e Hog 24 h e Fun letely	edicai	(Check only 2 Medicet Exemi	ner: On the basis of examination and manner stated.	and/or investigat	ion, in my opinion, death or	ccurred at the time	date and place	, and due t	o the cause(s)
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c. License number		29d. Date sign	ed (Month,	Day, Year)
)	3		Janz Stelle			138647		08-	17- 2	005
	B		30. Name and address of person who co							
_	3		FAURI KHARIL	1325 MT.	HER NON	Ro, SARIS	BURY 1	4) 218	04	
	Sta Registr	te	31. Date filed (Month Day G 1 8 2)	13 25 M7. 32. Figistrar's Signature	4	V .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 For State Registrar 28647 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer 2005 Eunice Godfrey 10:30 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crescent Cities Center Riverdale Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months Days Min. 1 ☐ M 2 ☐ XF Hours 22, 1920 100-70-1543 Feb. Guyana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Prince George's Maryland Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Stevenson Lane 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Beresford Clarke Antoinett Eliza Lyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Stevenson Lane, Landover, MD Patricia Parkinson/Daughter 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State `4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 8/17/2005 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis 1 Day Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Advanced Alzheimer's disease autopsy performed? res 2 No Dysphagia 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25079 August 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, filled in by the funeral director, Director: After within 24 hours of To the Funeral

Physician

/Medical

Examiner

Direct

Completed by Funeral

Be

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Funeral

Director

?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2: Department of Health ar Important: if item 27 Is any injury or other traconce.

Physician

/Medical

Examiner

filed within 72 hours after Hygiene.

altimore, Maryland 21215-0036

death with the Maryland

State Registrar

DHMH 17 Rev 1/2001

AUG 1 7 2005

31. Date filed (Month, Day, Year)

Don H. Yablonowitz, M.D. 7404 Executive Place, #502, Lanham-Seabrook MD 20706

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 20051 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Month **Physician** 10:15 AM John Richard Gorman 2005 August /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 1 Yeer) NOV • 11, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. r∐M 2□F Months Hours fowa 91 Yrs 569-14-1089 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examination must be notified at Annapolis 1 ☐ Yes 2 QNo Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21401 6110 River Crescent Drive U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. NOXYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 22No Specify: White Completed by WW II 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) US Naval Academy Instructor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Everett John Leonard Gorman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6110 River Crescent Drive Annapolis, MD Helma E. Gorman/wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 200 Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any Injury or 8/17/2005 Baltimore, Maryland Baltimore Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Cloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine **burial-transit** the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 þe 2 No 1 Ti Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 27 after death.

Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 20 Other: 1 Apatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 2 ER/Outpatient filled in by the funeral 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 T Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital o within 24 hours aft To the Funerel Di 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number ned (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of down (Item 23a) (Type, Print) oward 197 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 **AUG 17** Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Katherine Garrison 7:20 a M August 14, 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 3232 Geiger Avenue Kensington | Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year) | April 8, I Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1 ☐ M 2 ☑ F 1950 Washington, Yrs. 213-56-0142 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show the Medical Exertitive must be notified at 1 ☐ Yes 2 ☑ No Kensington Maryland Montgomery Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20895 USA 3115-1 University Blvd, West 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status iiled within 72 hours after 1 ☐ Yes 2√☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 XWidowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker ps 1 and 2 should be filed v of Health and Mental Hygie If item 27 is marked other t yr other treumatic event, IL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred C. Kidwell David Rodney Glasco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Glasco/ Brother 12215 South Debkay Court, Monrovia, Maryland21770 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' Department of P Important: If ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 19 * 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery Washington, DC 2005 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc CUIR 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Breast Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitet or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day ŏ 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2□ No certificate 1 ☐ Yes 2 (XNo 1 🗆 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 🔀 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Residence After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titl of certific August 16, 2005 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, #327, Olney, MD 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

			1 State of Maryland / Department of Health and N Certificate of Death		ene 200	5 28650
	Physici		1. Decedent's Name (First, Middle, Last) Louis GOROSH	2. Date of Death Month August	Day Year 13, 2005	3. Time of Death 5:45 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Landow House - 1799 E.Jefferson St. Ab. City, Town, or Location of Death Rockville		4c. County of Dear	h
	Funeral Director		5. Social Security Number 147-14-0563 6. Sex 7. Age (In yrs. last birthday) 1 W A 2 F 96 Yrs. 1 W Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 7,	9 Bird	hplace (State or Foreign untry) mania
	P	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Montgomery Rockville			10d. toside City Limits
	ith the Ma or 28a-f s	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	14 Yes 2 □ No untry?
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itams 23a or 28a-f show avant, the Medical Ever it er must be mailted at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, Whit	e, etc.
Maryland 21215-0036	72 hours a natural', o	by	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	ing 16	Specify: W	hite
2121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Acetylene Torch Operator		Sheet Me	tal
/land	ed fall	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name Corosch	e (First, Middle, Ma arah G	iden Sumame) reenburg	
_	and 2 sho eaith and I n 27 is ma		19a. Informant's Name/Relationship (Type, Print) Gail Bashein / daughter 7812 Mary Cassatt Driv			
Baltimore,	of Hitar		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or 5 Flushin	Town, State
Balti	permit. Pag Department Important: any injury		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Total 254 Carroll St., Ni			neral Home
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) a			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events C.			
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of): d.			
O. Box 68	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of del Month	very Day Year
٥.	quires that ti n signed by ald be detac	by	Part of Other significant continuous continuous to death out not resolving in the dilderlying cause given in Part I.		cco use contribute to	the cause of death?
Il Records,		Completed		24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	Physician this certific al director,	To Be	25. Was case referred to medical examiner?	me 5 Residence	e 6 □Other (Spec	city)
Division of	ling P		1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe how	injury occurred	
DIVIS	s after de salter de la Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Ru State)	ra I Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	and place, and due	to the cause(s)
)	To To To To To To To To To To To To To T	M	29b. Signature and fittle of certifier D 35436	A	Date signed (Month	4.2005
	4		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BINDING AND AND AND AND AND AND AND AND AND AND	, ROCKVI	LLE M.	520852
	Sta Registr		31. Date filed (Month, Day, Year) AUG 18 2005 32. Registrar's Signature			

			1- State of Maryland / Dep. Registrar Ce	artment of Health and N rtificate of Death		^{ne} 2005	28651	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	Wanda Faye Hooker	T 4 0 7 7 4 4 4 4 7	August 1		5:30 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) 2906 Fairlawn St.	4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince Geo	rgets	
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)		
	Director		579-70-3367 1□ M 2XF 51 Yrs.	Months Days Hours Min.	Jan. 11,			
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			d. Inside City Limits	
	Maryli f sho	ō	Maryland Prince George's Temple H				Y Yes 2 □ No	
	r 28a-	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?	
	th with		2906 Fairlawn St.	20748		USA		
	ems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Examber mutter could be a seen.	by	1 DNNever Married 2 □ Married 1 □ Yes 2 X□ No	1 ☐ Yes 3 ☐ No Specify:	,		Black	
S O	72 hc 'natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ina 16t	o. Kind of Business/Ind	ustry	
121	filed within 72 Hygiene. sther then "nel ent, Ins Wedic	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Pvt. Industry		
2	Hygie Hygie other ent, L	ပိ	12th L 17. Father's Name (First, Middle, Last)	aundry Presser 18. Mother's Name	e (First, Middle, Mai		ustry	
<u>a</u>		To Be	Augustus Hooker	Mary N	Villiams	3		
a _Z	2 should be and Mental Is marked (sammaric ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	City or Town, State, Zip Code)				
	1 an 1 an 1 an 1 an 1 an			Fairlawn St. Temp	ole Hills	MD 20748	3	
Baltimore,			I M Buriai 2 U Cremation 3 U Hemoval from State	osition (Name of Inatory or other place)	Date 200	. Location - City or Tov	vn, State	
<u>=</u>	t. Pag rtmen rtant: rjury		`4 Donation 5 Other (Specify) Lincoln			uitland, MI		
Ba	permit. Pages Department of I Important: If its any injury or of			2. Name and Address of Facility Mar 08 Suitland Rd.	rshall's l Suitland,		ne of MD	
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	ic brain co	incer		Onset and Death	
н	/Medical Examiner		Due to (or as a consequence of):					
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o Î	The law requires that the death certificate be executed that been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):					
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	entific ding p		IF FEMALE: 23c. If yes, outcome of pregnancy				-	
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ري ح	s that med b e deta	y Pl	Part II. Other significant conditions contributing to death but not resulting in the u			co use contribute to the	cause of death?	
ğ	en sig		Laryngeal cancer 5/P	laryngectomy	1 ☐ Yes	2□No 3M Proba	bły 4 ∐Unkno w n	
Vital Records,	law ri las be	ompieted			24a. Was an autopsy	24b. Were autop:	sy findings available	
r =		Con			performed	? death? No 1 ☐ Yes 2	pletion of cause of □ No	
Z	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	01	Check onli one			
Ö	Phys	2	1 ☐ Yes 2 ■ No ☐ I ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death		me 3 Residence 28d. Describe how in	6 Other (Specify)		
0	Attending I ir death. ector: After by the funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	Edd. Describe now i	njury occurred		
UNISION		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str	eet, factory, office	28f. Location (Street	and Number or Rural	Route Number,	
5	rs after salter	Cert			City or Town, Si			
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier 0 COO	29c. License number	29d.	Date signed (Month, D	ay, Year)	
	0		Kodney J. Ellis, M	1 0002135	26 AU	16, 21 TOUDS	005	
12	-(3)		30 Name and address of person who completed cause of death (Item 23a) (Type, Source L. Ellis, WD 9811 G	reemboit Kd +1	of La	name V	40 20706	
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 8 2005	W.				

State of Maryland / Department of Health and Mental Hygiene 2005 28652 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ruby D. Hargraves 12, 10:40pm M August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehab Center Clinton Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F 238-18-2680 87 July 18, 1918 Director North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23a or 28a-1 show Maryland the Medical Examiner must be notified at Prince George Springdale 1 Yes 2 No Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 500 Truman Drive 20774 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 10 1 ☐ Yes 2 🖸 No Specify. Black Specify: þ 3 ⊠ Widowed 4 □ Divorced natural, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Food Service Worker Private Pages 1 and 2 should be filled wi ment of Health and Mental Hygien ent: If Item 27 is marked other th oury or other fraumatic event, Ing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Davis Ila Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lela Wortham/Daughter 10515 Country Ridge Dr. Upper Marlboro, MD. 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Harmony Memorial Park Aug. 19,2005 Landover, MD. 1 Burial 2 Cremation 3 Removal from State permit Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility 20747 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Candiovarala Discore ATTERCOSCIENOTIC **Physician** /Medical Due to (or as a consequence of): Examiner Store Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatrent 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury To the Hospital or Attsndi within 24 hours after death. To the Funerel Director: A death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide 1🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1) KS 3 6 5 August 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidarous, M.D. 11701 Livingston Rd. Suite 101, Ft. Washington, Md. 20744 Registrar's Signature 31. Date filed (Month, Day, Year) State

H) DHMH 17 Rev 1/2001

Registrar

AUG 1 8 2005

State of Maryland / Department of Health and Mental Hygien 2005 28653 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Loretta Μ. Hodges 5:30p M August 12, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehabilitation Ctr. Prince George Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 13 F 63 577-56-1424 Director 30. 1941 Wash, Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10h County 10a State 10d. Inside City Limits 7 is marked other then "naturel", or Items 23s or 28a-f show treumatic event, the Medical Examinat must be notified at 1 Tr Yes 2 □ No Director Maryland Prince George Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 71st Avenue 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Blackwell Helen Young 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is Abraham Hodges/Spouse 315 71st Avenue, Seat Pleasant, Md. 20743 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑8urial 2 ☐ Cremation 3 ☐ Removal from State ō Maryland Veteran Cem. Aug. 18,2005 Cheltenham, Md.

22. Name and Address of Facility Pope Funeral Homes
5538 Marlboro Pike
Forestville, MD. 20747 A □ Donation 5 □ Other (Specify) injury 21. Signature of Funeral Service Licenses any ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fulfore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 les /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Ke that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE 981 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death the 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2X No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 ANatural 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident Director: in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060999 August 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Suite 415; Washington, D.C. 20010 Aruna Paspula, M.D. 106 Irving 31. Date filed (Month, Day, Year) State AUG 1 8 2005 Registrar DHMH 17 Rev 1/2001

5/2°

			1 - For State Registrar	State of Maryl		artment of F rtificate of I		Mental Hy	giene Reg. No. 20)5	28654
			Decedent's Name (First, Middle, La.	st)				2. Date of De	ath	3	. Time of Death
	Physici		Warren T.	Holmes				Month	13. 2005	rear	·45 р ^м
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	August	4c. County of	Death	÷45 P
34			Prince George's H	ospital Cent	or	Chever]	37		Prince	Coore	o t a
	Funeral		5. Social Security Number 6. S	ex 7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	h (Year)		(State or Foreign
L	Director		214-68-8645	⊠ M 2□F	48 Yrs.	Months Days	Hours Min.	March 1			gton,D.C.
	D > 2		Usual Residence of Decedent 10a. State 10b. County	100	City Town and	tine					
	anyla shov	<u>_</u>	Maryland Prince		City, Town or Lo	shington				100.	Inside City Limits 1 Yes 2 No
	he M	Director		dediges	TC. Wa						
	with t		10e. Street and Number	11 5		10f. Zip Code			10g. Citizen of Wh		
	eath	by Funerai	2214 Old Fort Hi	12. Was Decedent Ever i	in IIS 13	20744 Was Decedent of H		nacify Vac or No.	United	American	
	Iten d	Š	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces?	13.	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		White, etc.	ildian,
39	urs af	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	B1ack	
ŏ	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f show the Medical Examiner must be notified at	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busi	ness/Indust	ry
75	nin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of wor d)	king			,
2	d with	E O	Elonomary/Sociality (6 12)	1	Pol:	ice Offic	er		Govern	ment	
ğ	e file al Hy oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)		
Maryland 21215-0036	uld b Menta rrked	To E	William F. Holme	es			Shirle	y L. Car	ter		
an	1 and 2 sho Health and em 27 le m ther traum		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, St	ate, Zip Co	de)
			Shirley Holmes			Suitland		tland, M	d. 2074	5	
Baltimore,		- 1	20a. Method of Disposition 12∑ Burial 2 ☐ Cremation 3 ☐	Pompusi from State	 Place of Dispo cemetery, crei 	sition (Name of matory or other place	(a)	Date	20c. Location - Ci	ity or Town,	State
Ĕ	Pages nent of J ant: If its ury or o		4 □ Donation 5 □ Other (Specif	1.4	Lincoln	Memorial	Aug.	20,2005	Suitland	d. Md.	
a	permit. Departr Importa any Inje		21. Signature of Funeral Service Licer		22	2. Name and Addres	ss of Facility			500 30111	
<u>m</u>	89 = 89		Muette Ki	1000	4	lexander 5538 Mari	boro Pike	Funeral Forest	Homes; Mo	a ^A · 20	747
П			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		proximate erval Between
	Physician		Immediate Cause (Final disease or condition	RII OLA WIL	= tul.	Tais				On	set and Death
	Physician /Medical Examiner		resulting in death)	Due to (or as a con		Valvins?					
			Sequentially list conditions	b							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a son	sequence of).						
	nd rans	Examiner	that initiated events	c							
Ö	e exe		resulting in death) Last	Due to (or as a con	sequence of):						
68760	ate b hysic the b	edicai		d							
_	entific ding p	Me	IF FEMALE:	00- 14							
80	eath certif attending for use a	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy			23d. Date of Month		Year
Division of Vital Records, P.O. Box	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown	ofdeath 5L	Other (specify)					
٥.	w requires that the death cer been signed by the attendir should be detached for use		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause givi	en in Part I	23e Did to	bacco use contribi	ute to the ca	ause of death?
ds,	signe d be	d b	•		Tooling III III a	ndonying addoorgive	on are ditti	1 🗆 Y	. /		4 Dunknown
Ö	requestion to the second secon	Completed						-			
ž	elaw hasi	id II						24a. Was a autop	sy prio	or to comple	findings available ition of cause of
<u></u>	icate								2 □ No 1	Yes 2□	No
₹	ictar certif recto	Be	25. Was case referred to medical examiner?	Hospital:		. all Doa Othe	26. Place of Dea				
ō	Attending Physicien: The law requires that the death cert r death. r death. ector: Atler this certificate has been signed by the attending by the funerel director, page 2 should be detached for use a	<u>۱.</u>	1 ☑Yes 2 ☐ No 27. Manner of Death	1 Unpatient	2 反 ER/Outpatier 28b. Time of	IL SLI DOA	4 Inursing H		ence 6 Other		
no	ding h. After	盲	1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	7) Injury 20:43	Worl	Yes 2 No	1 20000	· in a collect		cal ca
2	deat deat ctor: y the	Certification:	3 Suicide 6 Could not be				.00 2 (),10	28f Location (S	LIST COLLAG	or Bural Bo	ute Number RD
<u> </u>	after Dire	erti	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)	oot, radiory, dilloo		City or Tow	n, State)	C 0:	MO RD
	Hospitel or 24 hours afte Funerel Dir tely filled in	C	29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, death	occurred at the tim	ne, date and place	and due to the d	ause(s) and mann	er as stated	
	• Ho • Fur etely	edicai	(Check only 2 Medical Exert one)	niner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my of	pinion, death occur	rred at the time, o	date and place, and	due to the	cause(s)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funerel director, page 2	Me	29b. Signature and title of certifier	١.		29c. License	e number	1	29d. Date signed (/	Month, Day,	Year)
			MOUND TO The	2 Uh 10 - N	da A	OCME		Δ	ugust 14	2005	;
0	(1)		30. Name and address of person who	completed cause of death (Item 23a) (Type			A	ugust 14	, 200.	
K	114		MAMAMO P	KUREU	-=/(-)		Street.	Baltimo	re, Mary	land 2	21201
P	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature		,		,		
	Registr	ar	AUG 1 7 2005	Klare A	F 65004						

			1 - State of Maryland / Dep	ertificate of Death	lental Hygie	ene 1. No. 2005 28655
	Dhycici	4	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physici /Medio		Paul Jerome Hamilton, Sr.		August	9 2005 2:50 P M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			11523 Waesche Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Mitchellv:) If Under 1 Year If Under 24 Hrs.		Prince George's
	Funeral Director		577-42-1612 1X M 2 F 73 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) Apr. 3,	
	ס		Usual Residence of Decedent		Apr. 5,	1932 Wash., DC
	arylar show	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	8e-f	ecto	Maryland Prince George's	<u>Mitchellville</u>		1X Yes 2 No
	with the sor 2	吉	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	eath	eral	11523 Waesche Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ocify Vac or No.	United States 14. Race - American Indian.
"	riten irer	Funeral Director	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married 1 Yes 2 □ No 1 Yes 6 1 Yes 7	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White, etc. African
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28e-f show deal Exac iller mail be mailled at	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 21 No Specify:		Specify: Affican American
2-0	72 hc	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working	16	b. Kind of Business/Industry
121	within ene. then "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	filed v Hygie other t		12th 17. Father's Name (First, Middle, Last)	Electrician 18. Mother's Name	(First Middle Ma	Government/Private
an	d be ental ked o c sve	To Be	Boyd Hamilton	lot mound of turno		Johnson
Maryland	should ind Men marke umatic	1		ing Address (Street and Number or Rura		
Š	s 1 and 2 of Health a item 27 is			523 Waesche Drive,		
ore	es 1 and the fitter roth		20a. Method of Disposition 1 □ Removal from State 20b. Place of Disposition 20b. Place of Disposition cemetery, creation 3 □ Removal from State	osition (Name of Dimatory or other place)	ate 20	c. Location - City or Town, State
Ě	Page nent c ant: If ury or		'4 □ Donation 5 □ Other (Specify) Maryland	Veterans Cem. 8/16	6/2005	Cheltenha, MD
Baltimore,	permit. Departr Imports any inju		21. Signature of Furieral Service Licenseen 2	2. Name and Address of Facility St 4001 Benning Roa		neral Home , DC 20019
			23a. Part . Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	r respiratory arrest	Interval Between
	Enysician		Immediate Cause (Final disease or condition and the cause of condition and the cause (Final disease or condition a			Onset and Death 32 Years
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Gauss (Liseese or injury			
ó	an an rial-tr	Еха	resulting in death) Last C. Due to (or as a consequence of):			
8760,	cate be execut ed physician and the burial-transit	Physiclan/Medical	d			
9	ertifica ling ph	Med	IF FEMALE:			
Вох	eath certific attending p	lan/		Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 [9 ☐ Unknown	Other (specify)		
o, O	res that igned b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	The law requires that the death certific its has been signed by the attending p bage 2 should be detached for use as				1 ☐ Yes	2 No 3 XProbably 4 Unknown
000	aw re	plet			24a. Was an	24b. Were autopsy findings available
Division of Vital Record	The tav ate has page 2	Completed			autopsy performe 1 ☐ Yes 2 X	prior to completion of cause of death? No 1 Yes 2 No
/ita	cian: ertific actor,	Be (25. Was case referred to medical examiner?	26. Place of Death		
of \	Physi this c al dire	卢	1 ☐ Yes 2 ₹ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			e 6 Other (Specify)
u	ding I	tlon	27. Magner of Death 1	of 28c. Injury at 2. Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how	injury occurred
IISI	or Attending Physician: The tafter death. Director: After this certificate ha in by the funeral director, page.	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm st		8f. Location (Stree	at and Number or Rural Route Number.
5	0 4 A S	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat a miner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, at vestigation, in my opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Step La Sland	D18219		August 12, 2005
R	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type,	,		
				cantile Lane, Largo	, MD 20	774
	Sta Registr	_	31. Date filed (AO) G 1 7 2005	roll o		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiener 1 - For Stete Registrar 28656 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15, 2005 5:25 p M Gordon Harvey Hedges, Sr. August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Health Care LaPlata Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foundation | Months | Days | Hours | Min. | OCT | 47, 1920 | Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 84 Yrs. Director 226-14-4812 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Charles Maryland Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3147 Fraser Road 20616 23a U.S.A. death Funerai Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman -Inspector U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Hedges Ruth Naomi Arrington 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra <u>once.</u> Mildred Louise Hedges Wife 3147 Fraser Road, Bryans Road, Md. 20b. Place of Disposition (Name of commetery, crematory or other place August 19, 2005

Maryland Veterans Cemetery Cheltenham, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Williams Funeral Home, 20640 Md. M00668 4270 HAwthorne Rd., Indian Head, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBTUREN Pnysician disease or condition resulting in death) /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed 47 resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No the 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2[] No 2 No 1 Yes Division of Vital 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner Other: 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 PNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Monti 1 8 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 14, 2005 **Physician** RAMONA S. HILL 2340 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Olney MONTGOMERY If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Feb. 13, 1921 84 Director Alabama 011-24-4890 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r than "neturel", or Items 23a or 28e-f shore the Medical Exercities of the Medical Exercities of Yes 2 No Directo Howard Woodbine MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1220 Adgate Court 21797 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩No Specify: à Specify: Black 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 le marked other than any injury or other treumatic event, If a Hands one Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Cook 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adel Spearman Fleeta Spears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1220 Adgate Court, Woodbine, MD 21797 Willie J. Hill, Jr (Son) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State Evergreen Cem. Beachton, GA 8/20/05 4 □ Donation 5 □ Other (Specify) Signalure of Funeral Service Licens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash St., Rockville, MD 20850 23a. Part1. Enter the disease, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 6 days /Medical Due to (or as a consequence of): **Examiner** End Stage Renal Failure Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit The law requires that the death certificate be executed the attending physician and C. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 □Unknown 1 Yes WNo Sick Sinus Syndrome Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy performed? page 1 Yes **2√** No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred lospitel or Attending P hours after death. unerel Director: After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D29300 8-16-05 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Dr., Olney, MD Robert Gold, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature bester 18 AUG 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28658

				Certificate of Death	Reg. No.	20000
	-: ·		Decedent's Neme (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Ļ	Physici /Medi		WEBSTER HOLDER		08-22-2005	834pm
	Examir		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. County of Death	
			TAIRDT HOSPICE HOUSE	EASTO	N TAUX	OT
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last bit)	nthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthp	place (State or Foreign
,	Director		214-12-5034 10M 20F 94	Yrs. World's Days Hours Will.	02-14-1911	""Inn
	ס	•	Usual Residence of Decedent			
	yan how		10a. State 10b. County 10c. City, Tov	m or Location	1	0d. Inside City Limits
	Ma-fa	ţ	IND CAKOUNE HEDE	EXALSBURG		1 MYYes 2 □ No
	h th	1	10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Cour	ntry?
	h wil	Funeral Director	316 EAST (JEUTZAL AVEN	UE 21632	USA	
	dea dea	ne	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexicen, Puerto	pecify Yes or No- Rican, etc.) 14. Race - Americ Black, White,	
0	of the		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 Yes 2 No Specify:	1 11	1 1 77-
00	ours o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	TEL TES ZIZINO Specify.	Specify: WH	1116
9	within 72 hours effer death with the Maryland ene. than "natural", or Hems 23a or 28a-f ahow he Medical Examinet must be notified at	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Ind	dustry
21215-0020	thin .	ple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		INCOR IOUV
2	e filed within el Hygiene. I other than 'vent, the Me	PO.	8	MACHINE OPERA	TOR NYLON MAN	VFACTURING
Maryland	Hygie other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname)	1
ā	Mentel Mentel mrked o	ToE	JAMES HOLDER	OUVI	A UNKNOWN	J
a Z	2 should end Men ia marke aumetic		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or Run	al Route Number, City or Town, State, Zip	Code
	s 1 end 2 should be filed within 72 hours efter death with the Maryfar if Heelth end Mentel Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f ahow other traumatic event, the Medical Examiner must be notified at		GEDERE HOLDERISON (A	IUD WHEATT PUKOA	DHEDERRALSBURI	21632
ē,	Heelth tem 27 i	7	20a. Method of Disposition 20b. Place of	of Disposition (Name of ery, crematory or other place)	Date 20c. Location - City or To	wn, State
9	8 = 5		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	PADD (+METERU)	BIJSIOS PO DOPAN	o mp
Baltimore,	nit. Pa entman ortant: injury		21. Signature of Funeral Service Licensee	22 Name and Address of Facility	129 - 20021150) //
Ba	Deperment of the perment of the permet of the perment of the permet o		21. Signature of Fulleral Service Elcensee	22. Name and Address of Facility WILLIAMSON FUND	RALHOME	20 2 /-
			CO CO		LEETFEDERALSBUK	
			23a. Part1. Enter the disease, or complications that ceused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician				1	Onset and Death
4	/Medical Examiner		Immediate Cause (Final disease or condition Me ta startic Li	imphona (Liver)		
	Examiner "			consequence of):		
_	P #	Examiner	- h		i	
	aath certificate ba axecuted attending physician and for use es the buriel-transit	ш		consequence of):		
Ö	a axe	ũ	if any, leading to immediate cause. Enter Underlying			
68760,	ysic he b	edical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a	consequence of):	1	
	ntifice ng pt	Med	Tooling in doubly Edd.		1	
Box	endir nuse	2	d			
	daath e atten ed for u	SICI	Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I.	23b. Did tobacco usa contributa to	tha causa of death?
0.0	by the	ţ	This law of the total		1 ☐ Yes 2 No 3 ☐ Prol	bably 4 Unknown
	s tha	by Physician	Diahetes - Non insuli dependent			
Division of Vital Records,	v requiras that the daath cer been signed by the attendin should be detached for use	8			24a. Was an autopsy performed? 24b. We	ere autopsy findings ailable prior to
ပ္ပ	law renas bec	Set			co	mpletion of cause death?
æ	The law ate has page 2	Completed			111 Yes 21 No 10]Yes 2□No
a	n: ∏ ficate or, pe		25. Was case referred to medical	26 Place of Post	h (Check only one)	3103 203110
5	Physician: this certific rral director,	9 Be	examiner?	Other		- T
o	Phys this ral d	: To			ome 5 Residence 6 Other (Specif) 28d. Describe how injury occurred	TOSPICE .
ב	Ilng After fune	<u>o</u>	1 Natural 5 □ Pending (Month, Day Year)	Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	,.,	rouse
S	Attending ir deeth. ector: After by the fune	ca	3 Suicide 6 Could not be		28f. Location (Street and Number or Rura	i Route Number
\leq	or Al	ŧ	4 Homicide determined building, etc. (Specify)	ini, street, ractory, onice	City or Town, State)	, rigato riambol,
	To the Hospital or Attending Physician: The is within 24 hours after deeth. To the Funeral Director: After this certificate he completaly filled in by the funeral director, page	edical Certification:	20a Cartifier Physician T- the heat of any translation	a dooth accurred at the time data and alternative	and due to the course(s) and manner and	nted
	Hosi 24 ho Fund taly f	Ica	29a. Certifier Check only (Check only (Che			
	the the	Med	one) and manner stated.	29c. License number	29d. Date signed (Month,	Day Year)
	or viting to the contract of t	~	29b. Signature and title of certifier		Zau. Date signed (Month,	Duy, 10al)
			Gios A Amita Do	(20003304	8/26/5	
			30. Name and eddress of person who completed cause of death (Item 23a)	(Type, Print)		
_			CURTIS A. Amith DD.	314 South Contral	awal Dela	uno 19936
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	1. 4.		
	Registr	rar	AUG 2 6 2005 Alleria 15	Albert Control		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Hubert Isner 15, 2005 August 8:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brook Grove Nursing Home Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
March 15, 1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F 235-20-0996 83 Director Parson, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Montgomery Sandy Spring 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code With 18100 Slade School Road 20860 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 r itment of Health and Mental Hygiene.
 rtent: If item 27 is marked other than "naturalizary or other treumatic event," I'm Nicolizar 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer CIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Isner Naomi Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Isner (wife) 18100 Slade School Road Sandy Spring, MD 20860 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 8/18/2005 Brentwood, MD permit.
Departr
Importe
any inju 21. Signature of Funeral Service Mense 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760 physician by Physician/Medical attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed Vascular Dementia 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: At Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ♣No 2 Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 33700 8/18/2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ted Howe, M.D. 154 Artizan st. Williamsport, MD 31. Date filed (Month, Day, Year) AUG 1 8 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 200528660 For State Registra Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST **Physician** 14, 2005 9:55P M FRANCES ANN JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M XXF Yrs Director VIRGINIA 61 1944 229 56 7350 Usual Residence of Decedent e filed within 72 hours after death with the Maryland il Hygiene. other than "natural", or liams 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show XX Yes 2 No PRINCE GEORGES MARYLAND CLINTON Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code PRINCE GEORGES 9106 PINEVIEW LANE 20735 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🔀 🗓 No þ Specify: BLACK 3 Widowed XX Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH PRIVATE C.N.A. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic event, since. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CINDY TOLSON ANDREW L. ASHTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) GEORGE JOHNSON / SON 296 LUTTRELLVILLE RD. CALLAO, VA 22435 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State SILOAM CHURCH CEMETERY 8/20/2005 4 □ Donation 5 □ Other (Specify) MONTROSS, VA 21. Si na re of Fynayal Service Licensee MARSHALL'S FUNERAL HOME OF MD/FISHER FUNERAL HOM 4308 SUITLAND RD. SUITLAND, MD / OLDHAMS, VA Approximate Interval Between Onset and Death Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, br heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia Bilateral Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 DEctooic oregnancy 1 Live birth in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 7 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tipe 29c. License number 29d. Date signed (Month, Day, Year) Mil D0055120 200 €

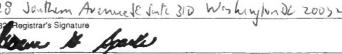
State Registra

31. Date liled (Month, Day, Year) AUG 1 8 2005

MD

Richard Yalner

30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print) 1358



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. o.

			1 - State State of Maryland / De State of Maryland / De State	epartment of Healti Certificate of Deal	n and Mental Hy <i>th</i>	giene 200	5 28661
	Physici	an	1. Decedent's Name (First, Middle, Last) Margarot Ann Jon	0.0	2. Date of De	13 ^{Day} 2005 ^{Yeer}	3. Time of Death
	/Medic	al	Margaret Ann Jon: 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		13, 2005 4c. County of Dec	
	Examili	er	Heritage Harbour Health & Rehabili	·		Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Und	der 24 Hrs. 8. Date of Bir	th 9. Bi	rthplace (State or Foreign Country) hington, DC
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 10c.	or Location			10d. Inside City Limits
	death with the Maryland ms 23s or 28a-f show Littust by Exclifted at	tor	MD Anne Arundel Edgewate	er			1 Tyes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	s 23s	rall	411 Hamlet Club Drive	21037		United Sta	
920	be filed within 72 hours after death with the Marylan del Hygliene. Ide Hygliene. Ide Hygliene. Instruction of the mass of 28e-1 showers, the Medical Examination of the confilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ▷ ▷ ▷ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 ☒ No Spec		14. Race - Am Black, Wh Specify: Wh	ite, etc.
21215-0036	filed within 72 ho Hygiene. Ither than "natuent, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during rr life. DO NOT use retired)	nost of working	16b. Kind of Business	
2	filed v Hygie other t		12 Sec 17. Father's Name (First, Middle, Last)	cretary 18. Mo	other's Name (First, Middle	Universit	У
<u>a</u>	should be nd Mental marked o	To Be	Harry Sturgis		garet	(not av	ail.)
Maryland	es 1 and 2 should b of Health and Ment f item 27 is marked r other treumatic e			Mailing Address (Street and Num l Hamlet Club I			Zip Code)
Baltimore,	Pages 1 a ment of He ent: If item ury or othe		1 - Durian 2 Moralination 3 - Hallioval Italia 3 tata	Disposition (Name of crematory or other place) litan Crematory	Aug. 15, 2005	20c. Location - City of	
3a	permit. Page Department of Importent: If any injury or once.		21 Signature of Fund at Service Licensee	22. Name and Address of Fa		eral & Crem	ation Service
			M00982	42 Hudson St.,			
L	Physician /Medical		23a. Part1. Enter the disease, or complications that ceused the death. Do not shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death)	diatin	as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Examiner	ē	Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	en gly com	· _		
	cuted id ansit	Examin	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events				
68760,	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last Due to (or as a consequence of) d.	:			
	ntificate I ng physi as the t		IF FEMALE:				
O. Box	uires that the death cert signed by the attendin d be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2	3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
ρ. J	requires that een signed by hould be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Par	23e. Did to	obacco use contribute to	the cause of death?
Hecord		lete	Deloction Mel	h -	24a. Was	1	utopsy findings available
_	The ate h page	e Completed	25. Was case referred to medical		autop perio 1 \(\text{Yes}	rmed? prior to death? 2 No 1 ☐ Yes	completion of cause of
=	Physicien: this certific ral director,	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Other "	ace of Death Check onl o		city)
	ding Physicien: After this certific funeral director,	no:T	27. Manner of Death 1 Statural 5 □ Pending (Month, Day Year) 28b. Tim (Month, Day Year)	ne of 28c. Injury at	_	ow injury occurred	o.i,y)
VISION	tendii leath. tor: A the fu	catle	2 Accident investigation	M 1 ☐ Yes 2			
2	ital or Al	Certification:	4 Homicide determined 288. Place of Injury - At nome, farm building, etc. (Specify)		City or Tow		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	feath occurred at the time, date or investigation, in my opinion, d	and place, and due to the death occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To To con	2	29b. Signature and title of certifier M M M M M M M M M M M M M	29c. License numbe	7867	29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print) to 100	Elliano	ty wi)	Diorf7
1	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 7 2005 32. Registrar's Signature	book			

			1 - State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H	lealth and N Death	Mental Hygi ™	ene g. No. 20 ()5	28662	
			1. Decedent's Name (First, Middle, Las					2. Date of Death Month	1		3. Time of Death	
	Physici		Paul Nam Kang					August		_{Уваг} 005	10:40 P M	
10	/Medio Examin		4a. Facility Name (If not institution, give	e street and number	or)	4b. City, Town, or	Location of Death		4c. County o	f Death		
			University of Mary	land Med	ical Center	Baltimo	ore		N/	A		
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs. last birthday	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl	ace (State or Foreign	
	Director	ļ	214-80-3263	⊠ M 2□F	42 Yrs.				1963			
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	Od. Inside City Limits	
	sho	5									1 ☐ Yes 2 ☐ No	
	788-f	Director	Maryland Montgo 10e. Street and Number	mery	Silver	Spring 101. Zip Code		10	og. Citizen of Wi	nat Coun	trv?	
	with with	늅	106. Sileet allo Number								,	
	eath	era	14005 Wagon Way	12. Was Decede	nt Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	USA 14. Race	- America	an Indian,	
40	hours after death with the Maryland ure!; or Items 23s or 28s-f show at Examiner must be rediffed at	Funerai	1 Never Married 25 Married	Armed Force	s?	Il Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		, White, e		
936	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:	1 ☐ Yes 21/2 No	Specify:		Specify:	Asi	an	
21215-0036	72 ho	Completed	15. Decedent's Ec	ducation		edent's Usual Occup			6b. Kind of Bus	iness/Inc	lustry	
218	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4c	lite.	DO NOT use retired	d)	9				
	er th	Con		3	Auto	Body Pair					ployed	
nd	d oth	Be	17. Father's Name (First, Middle, Last))			18. Mother's Nam	ne (First, Middle, M	faiden Sumame)		
yla	Men	70	J. Kummo Kang		10.00			Park	01 T 0		0.41	
Maryland	d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r traumatic event, the Mad		19a. Informant's Name/Relationship (ing Address (Street					Code)	
_	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the marked other then "nature!", or Items 23a or 28a-f show then traumatic event. The Madical Example or must be collised at		Mung-Ju An/ Wife 20a. Method of Disposition		20b. Place of Disp	05 Wagon V			Md 20 20c. Location - C		wn, State	
Baltimore,	or o		1 🖫 Burial 2 🗀 Cremation 3 🗆		te cemetery, cre	ematory or other plac	Auc	just 19.				
Iţin	ritmer ritant		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Liver			's Cemete 22. Name and Addre		005 <u>R</u>	ockville	≘, Ma	aryland	
Ва	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra 2009.). S. Sal		ing,	MD 20901						
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	ock, or heart fature. List only one cause on each line. Into Cause (Final or condition) Multiple invenes				Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition	2	Multiple !	numes					Onset and Death	
4	/Medical		resulting in death)	Due to (or		,				5103410 5341		
	Examiner	L	Sequentially list conditions,	b	- 13							
	p is	Examiner	franky leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to for	as a consequence of):							
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):							
8760,	icate be executed physicien and s the burial-transit	BIE										
387	phys phys s the	dicai		_ d								
9 X	the death certific y the attending p Iched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnancy				23d. Date	of delive	iry	
Box	atter atter	ciar	in the past 12 months?			□Ectopic pregnancy □ Other (specify) _	<u> </u>		Mont	th	Day Year	
P.O.	by the tached	ysi	9 Unknown	9☐ Unknow	1	0.2004						
	requires thet een signed b nould be deta		Part II. Other significant conditions of	contributing to deat	h but not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	acco use contril	bute to th	e cause of death?	
rds	quire n sig uld b	Completed by						1 ☐ Ye	s 20 No	∃ Prob	ably 4 □Unknown	
00	> 0 70	piet						24a. Was ar			psy lindings available	
Re	o E g	E						perform	ned? de	ath?	npletion of cause of 2□ No	
ita	ician: Th certificate ector, pag	a	25. Was case referred to medical				26. Place of Dea	th (Check only one				
f <	Physician: this certific ral director,	To B	examiner? 1 XYes 2 □ No	Hospital: 1 📉 Inp	atient 2 ER/Outpatie	ent 3 DOA	ner: 4 ☐ Nursing H	ome 5 Reside	nce 6 □Othe	(Specify	<i>ı</i>)	
0			27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of I (Month,	njury 28b. Time Day <u>Y</u> ear) Injury	Wor		28d. Describe ho	- A		er in	
Θ̈́	Attending r death. sctor: After by the fune	atic	2 Accident investigatio	01/21	75 7:55	PM 10	Yes 2 No	motor value				
Division of Vital Records,	or Atta	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At home, farm, s etc. (Specify)	treet, lactory, office		281. Location (Str City or Town	, State)	or Ruma	1 Route Number, 2 13 SB 21.	
	urs el				1000			29 Colum	-		-	
	To the Hospital or Attend within 24 hours efter death To the Funerel Director: completely filled in by the	edical			est of my knowledge, dea s of examination and/or stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed	(Month,	Day, Year)	
	20		Darkes In Raise	HALL MA		0.	C.M.E.	A	ugust 1	6, 2	005	
	20		30. Name and address of person who	completed cause	of death (Item 23a) (Type	e, Print)						
			Pameler E. South		11	1 Penn St	reet, Bal	Ltimore,	Marylan	d 21	201	
	St	te	31. Date liled (Month, Day, Year)		istrar's Signature	market !						
	Regist	ar	AUG 18	CUUN CUUN	CURS SU PRO							

State of Maryland / Department of Health and Mental Hygiens 005 28663 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:00A. M August 13, 2005 Nancy C. K. Lininger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick **Buckinghams Choice** Adamstown Birthplace (State or Foreign
Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 F June 11, 1917 Pennsylvania Yrs. 88 196-14-1196 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examinations as be notified at 28a-f show 1 Yes 2 No Adamstown Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21710-9615 U.S.A. 7074 Upland Ridge Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home Pages 1 and 2 should be filed venent of Health and Mental Hygiesut; If item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Boyer Harry M. Kirkpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7074 Upland Ridge Drive, Adamstown, Maryland 21710 Fred T. Lininger altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 8-15-2005 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21 Signatur of Funeral Service Licensee 22. Name and Address of Facility Colonial Funeral Home 201 Edwards Ferry Rd., N.E., Leesburg, Virginia ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rable on each line. Approximate Interval Between 23a. Part1. Enter the con ease, or complicate shock, or heart former. List only one Onset and Death Immediate Cause (Final disease or condition resulting in death) evitone Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed Вох 68760, д resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes certificate or Attending Physicien: 26. Place of Death (Check only on 25. Was case referred to medical Be examiner Hospital: 1 | Inpatient Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation death. filled in by the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD0058726 - ruy) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mixmuelle 3000-0 Varkview Medical Gromp Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Registrar AMEND ITEM #23a&b,23PII,&23e PIR PHY C847 9/01/05 JH . Decedent's Name (First, Middle, Last) ate of Death 3. Time of Death **Physician** Month Day Frances Carolyn Ledwell 7:40 2005 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kline Hospice House Mt. Airy Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Year) 1 ☐ M 2 🖾 F Hours Min. Director 202-38-4129 73 17, 1931 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23a death v 10849 Utica Court 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filled within 72 hours after or nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or iter Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Executive Assistant Bulk Mail Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Stephen Joseph Hauser, Sr. Anna Marie Globisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 10849 Utica Court, Thurmont, Maryland Tom Ledwell, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8/27/2005 Smithsburg, Maryland ne of Funeral Service Lic 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701 M00999 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, other failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician Extensive Liver Metastasis 3mos resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Pancreatic Carcinoma
Due to (or as a consequence of): 6mos Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be exacuted p that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a detached t 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☑ Yo 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should Carcinoid TUMOR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) \(\)Hospice 1 ☐ Yes 2 💢 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending after death. Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 14626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Gregory Rausch Stree 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

41.00 Moulds 213-76-6319

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 28665 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Hilda Debbra Moulds 2140 14 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . Examiner WINSULA ICOMICO ea/ons If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 200 F Yrs Director 213-76-6319 46 3/18/1959 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked othar than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Delaware Directo Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 Mallard Lake 19975 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced white "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If itam 27 is marked othar than any injury or other traumatic event. The Mean injury or other traumatic event. Elementary/Secondary (0-12) Coltege (1-4or 5+) Sales Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Loudermilk Victoria Liphart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Mandes/daughter 1171 Holly Ave., Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8-16-05 * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Lig 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ENVEPHALOIATHY AnyI AMOXIL /Medical Due to (or as a consequence of): **Examiner** LAADIAL ABBES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit UARPIOMYOPATI ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical HYPEATENSION I ASEUD IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2× No Hospital: 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

M.D.

distrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chod NICK.

8

LENNIS

31. Date filed (Month.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 28666 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13 2005 6:25 p M August Hazel Alice Louise Orgass /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Crofton Crofton Convalescent Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min 1 ☐ M 2 🛱 F Director 056-52-0489 106 12,1898 Minnesota Usual Residence of Decedent os i and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene item 27 is marked other then "natural" or lines for the files from th 10c. City, Town or Location 10d. In side City Limits 10a. State 10b. County item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at 1 Yes 2 No Crownsville MD Anne Arundel Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21032 USA 1014 Plum Creek Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 200 No White Specify: þ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If item 27 Is marked oth any injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) Be Alvina Stein Henry Gugisberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1014 Plum Creek Drive, Crownsville, MD 21032 Susan M. Izant (Great-Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8-15-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the diserce, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or head failur. List only one cause of each line. Im lediate Cause Final dis lase of condition resulting in deat KENAL BAYS **Physician** /Medical **Examiner** DEHYDRATION WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part I). Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 23 No 2 No 1 Yes 1 Tyes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Dther: 1 ☐ Yes 2 XNo ို 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: within 24 hours after death. To the Funerel Director: After 1 Natural 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)31136 AUGUST 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDERD, BALTIMORE MD 21236 1SRIAN WALLACE, MD 9005 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and M	lental Hygie	ne 2005	28667
		п	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		JOHN ALBERT EDWARD ORLOSKI			Day Year L5 2005	3:00 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
		•,	Holy Cross Hospital	Silver Spring		Montgom	ery
r	Funeral Director		5. Social Security Number 577 . 14 . 8574 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 7. Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign ountry)
			Usual Residence of Decedent		April 19	,1908 Scr	anton, PA
	nylane how		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	a Ma	ctor	Maryland Montgomery Silver	Spring			1X Yes 2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	puntry?
	s 23e	ral	3114 Gracefield Road, Suite #511	20904		U.S.A.	
	ter de Item	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spe If Yes, sp <i>eci</i> fy Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
920	urs af	by		1 ☐ Yes 2X No Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland 'naturel', or Items 23a or 28a-f ahow dical Examiner must be notified at	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation	16b	. Kind of Business/	Industry
2	ithin ithin	nple		kind of work done during most of worki DO NOT use retired)		Industria	1
2	lled w lygier her th			lustrial Economist		Industria Developme	nt
anc	i be fi	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	len Sumame)	
Maryland	should nd Me mark matic	2	Anthony Orloski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Josephin Jos		nbeski	T- 0- 1-1
	nd 2 suith ar						
Ē,	item item		20a. Method of Disposition 20b. Place of Dispo	Gracefield Road, a sition (Name of natory or other place)	ate 20c.	Location - City or	S MD 20904 Town, State
E	Page Int. I		A Deliai 2 Oremation 3 Memoval nom State	Heaven Ceme. 8/22/	2005 Si	lver Spri	ing, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "naturel", or Items 23a or 28a-f ahow any injury or other traumatic evant, Ite Medical Examiner must be netitived at once.			2. Name and Address of Facility INES-RINALDI FUNER			
_	20 = 20	15	Noncy A, lecentry	<u>1800 New Hampshire</u>	Ave, Sil	ver Sprin	ng, MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Pnysician /Medical Examiner	i	Immediate Cause (Final disease or condition and the cause of condition and the cause of condition and the cause of cause	cident			Onset and Death Days
		incal limm disease resultiner	Due to (or as a consequence of):				
		<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Atrial Fibrillation Due to (or as a consequence of):	on			Years
	uted Insit	min	Cause, Enter Underlying Cause (Disease or injury				
Ó	exec an an rial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit	dlcal	d				
9	artifica ing pt e as t		IF FEMALE:				
Вох	death certific e attending p od for use as	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deli-	very Day Year
o.	0 0 0	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		WOITH	Day real
α.	res that I Igned by be detar		Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacc	use contribute to	the cause of death?
Records,	requires that the een slgned by th hould be detache	d by			1 🗆 Yes	2⊠No 3∏Pro	bably 4 Unknown
000	> 0 0	Completed			24a. Was an	24b. Were aut	opsy findings available
	e de	mo:			autopsy performed?	prior to c death?	ompletion of cause of
Vital	iclen: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☒ N	10 105	2□ No
	Physiclen: r this certific ral director,	٥ ا	1 ☐ Yes 2 🔀 No Hospital: 1 🔀 Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Hom	ne 5 Residence	6 ☐Other (Spec	ify)
Division of	ding P. h. After i funera	-io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how in	ury occurred	
SIC	ten deat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	M 1 Yes 2 No	06 1 10 1		
2	p # fe c	ertificati	4 Homicide determined 289. Place of Injury - At nome, farm, stre	eet, ractory, office	8f. Location (Street: City or Town, Sta	and Number or Rui te)	al Route Number,
	spita ours naral fillec	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	s) and manner as	stated
	he Hos n 24 h he Fun pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invalid	estigation, in my opinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
	To the P within 24 To the F complete	ž	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
	12		flormed MO	D-34590	Αι	igust 17,	2005
	v		30. Name and address of person who completed cause of death (Item 23a) (Type, F			2004	
	-0		Roy Fried, MD, 3110 Gracefield Road, 31. Date filed (Month, Day, Year) 32 Registrar's Signature		aryland 20	J9U4 	
	Stat Registra	_	AUG 18 2005	the same			
			1-00-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 For State Registra Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Ruth OSBAND August 15, 2005 8:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Convalescent Center Crofton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 84 1 ☐ M 2 🗓 F Months Days Hours Min. 1920 PA Director Nov. 155-03-0002 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State Item 27 is marked other then "natural", or Items 23e or 28a-f show other traumatic event, the Medical Examination will be examined at 1X Yes 2 □ No Anne Arundel Crofton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Rd. 21114 USA filed within 72 hours after death Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Hisnt: If Item 27 Is marked off Be Anna Abramson Herman Gurst 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 728 N. Watford Court Sterling, VA Maxine Fowler / daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Rodef Shalom Cemetery 08/18/05 Pleasantville, NJ `4 ☐Donation 5 ☐ Other (Specify) injury 21. Signature of Foresal Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home any in 254 Carroll St., NW, Washington, DC 20012 23a. Panth Thier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Carotid Arrythmia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Failure to Thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Dementia autopsy The performed' 1 ☐ Yes 2 X No Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 3∏ DOA Certification: To this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After or Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Diractor 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 29a. Certifier 14 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ti le of certifier 0 D 57028 August 16, 2005 son who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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(Month, Day, Year)

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#231, Annapolis, MD 21401

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State of Maryland / Department of Health and Mental Hygiene 2 1 1 5

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Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUG. 15, 2005 20:52 M **Physician** BANSARI D. PAREKH /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGE FORT WASHINGTON FORT WASHINGTON HOSPITAL 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days MOMBASA, KENYA 59 231-39-2160 Vrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No FORT WASHINGTON MD PRINCE GEORGE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ items 23a 20744 USA 10038 EDGEWATER TERRACE Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: ASIAN/INDIAN 1 ☐ Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ŏ Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Health end Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL ASSISTANT MEDICAL 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be JAYAKUMARI SHAH SHANTILAL SANGHAVEE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 10038 EDGEWATER TERRACE, FORT WASHINGTON, MD 20744 DILIPKUMAR PAREKH-HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Peges 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) NO. VA CREMATORY 08/18/05 ARLINGTON, VA 22. Name and Address of Facility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licensee 3901 N. FAIRFAX DR., ARLINGTON, VA 22203 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-taffure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive neart **Physician** /Medical Due to (or as a consequence of): Examiner 10M40 pathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ¹nce Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No tension autopsy performed Mellitus 2 No Diabetes 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannet of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by I filled To the Hospitet 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ft. Wash. Med. Livingston Rd. Dachdeva MD AUG 1 & 20 32. Registrar's Signature State 1 8 2005

DHMH 17 Rev 1/2001

Registrar

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				6. Sex	7. Age (In	yrs. last birthday		1 Year		24 Hrs.	8. Date of Birth			hplace (State or Foreign buntry)
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Physician / Medical Examiner Pagistrar			2	Ob. Place of Disp cemetery, cre	osition (Nan	ne of		D	ate	20c. Loc	ation - City or	Town, State		
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	Fo th within Fo the	Me	29b. Signature and title of certif	ie)			290	. Licens	e number		2	29d. Date	signed (Mont	h, Day, Year)
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R	(6)		30. Name and address of person			(Item 23a) (Type	, Print)							
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	Registr	al	MOGIO	COOJ DE	BALL)	The page 1								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 2867 I 1 - For State Ragistrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yee Month **Physician** 7:15 am August 16, 2005 Betty Ann Palmer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9304 Peerless Road Bishopville Worcester If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 5/17/1928 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Vear 1 □ M 2 🗙 F 77 220-26-3963 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a State 28e-f show other traumatic evant, the Modical Examiner and be notified at 1 ☐ Yes 2X No Directo Maryland Worcester Bishopville 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 5 9304 Peerless Road 21813 USA or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☑ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic average. 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Paul C. Long Alice Latchum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John R. Palmer/husband 9304 Peerless Rd., Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State ' 4 Donation 5 Dother (Specify) Bishopville Cemetery 8/20/05 Bishopville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association Salisbury, MD 21804
Approximate Interval Between Onset and Death Coull (FSP 501 Snow Hill Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) rosta **Physician** /Medical Due to (or as a consequence of) Examiner Ot. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transi ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Onknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2□ No 1 🗌 Yes 2 No 1 Yes Hospitel or Attanding Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funarel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of systemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 33796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riverside Drive Salsbury MD 560 David T. Walker MD 32. A gistrar's Signature State AUGT 8 2005 Registrar

DHMH 17 Rev 1/2001

RICHARD PARKER

MATTHEW PURDUM
05-5539

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 28673 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 16, 2005 0758 **PURDUM** AUGUST MATTHEW GEORGE /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK BALTIMORE UNIVERSITY HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 212-06-0042 1X M 2 ☐ F Yrs. 9 1984 Maryland Director Feb. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rei', or iteme 23a or 28a-f show Examiner must be notified at Frederick MD Frederick 1 Yes 2 XNo Directo 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21703 USA 6715A Overton Circle deeth Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agency Licensing Coordinator 12 Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Laurie Anne Dove John Maurice Purdum ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If Item 27 ie eny injury or other treu 2006. father 17511 White Ground Rd. Boyds. MD 20841 John M. Purdum 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/22/05 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory Frederick MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hilton Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of sping, such as cardiac or respiratory arrest.

Approximate shock, or heert failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lultiple **Physician** /Medical Due to (or as a consequence of): **E**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of de ↑?
1 La Yes 2 □ No autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 □Xes 2 □ No Medicai Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Operator of motocycle After Injury 5 Pending investigation s effer de-rei Director: Affe hy the fr 1 Natural 1 ☐ Yes 2 No 6:33 AM involved in MVA 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 85 & Green tield R 6 □ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide Adamstown MD within 24 hours e To the Funerei I 1 Certifying Physician: To the best of my knowledge, deal occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 17, 2005 OCME person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 31. Date filed (Month Day. gistrar's Signa State Registrar

James Carroll Rodgers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-05733 State of Maryland / Department of Health and Mental Hygiene 2005 RPD 28674 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician CARROLL RODGERS 2005 JAMES August 0840 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles <u> Hughesville</u> 231 @ I 381 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 220-62-7721 DEC.31,1953 WASH.,DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director HUGHESVILLE MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20637 U.S.A. ROAD 6270 BRANDYWINE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XIXNo Specify: þ WHITE 3 ☐ Widowed 4 ∑ Qivorced permit. Pages 1 and 2 should be filled within 72 hour. Deperment of Health and Mental Hyglene. Important: If item 27 ie marked other then "natural; eny injury or other traumatic event, the Michael Exp. 2002. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR CEEMAR CONSTRUCTION 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FINLEY AURELIA MARGARET RODGERS, LEE19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 20th AVE.N., ST. PETERSBURG, FL 33713 AMY LUQUETTE-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS 8-31-05 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 FUNERAL SERVICE, P.A. RAYMOND D not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ontact Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physicien: The law requires thet the death certificate be executed nding physicien and use as the buriel-transit thal initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2□ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCENE Medical Certification; To 1 ☐¥Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending Subject shot seed 1 ☐ Yes 2 📉 No and 8/25/05 Famel 8:20 M Director: A 2 Accident investigation 3 Suicide 4 ☐ Homicide 6 Could not be determined Location (Street and Number or Rural Route Number City or Town, State) Jumples Corner Javan 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by inside the car on Parling lot 1251 and [381, Hughsville, MD To the Hospital within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier *XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier inclas A O.C.M.E. August 26, 2005 ause of death (Item 23a) (Type, Print) APIUCIAN 111 Penn Street, Baltimore, Maryland 21201

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32 Aegistrar's Signature

2005

State of Maryland / Department of Health and Mental Hy

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	Funeral Director
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 12 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event. Ite Madical Examiner must be notified at once.
F. F	Physician /Medical
A. Carrier	AMedical

1 - State Registrar			Certificate of Death				Reg. No. 2005 286 / 3		
April 7 R	1. De	cedent's Name (First, Middle				2. Date of Death Month			
Physician /Medical		WILLIE THO	MAS SMALL				August 4	, 2005 Year	1140 A M
Examiner		acility Name (If not institution	n, give street and number)		4b. City, Town,	or Location of Death		4c. County of Death	
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	23a.	Part1. Enter the disease, or shock, or heart failure. List	r complications that caused the only one cause on each line	ne death. Do not en	er the mode of dy	ing, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
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Medical	resu	ilting in death)	a. Hypevita	consequence of):	Atheroso	devotic	Cardion	rscuoas	
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		and an additional and a second	Due to (or as a	consequence or).					
ž g			d						
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or us	23b.	Was decedent pregnant in the past 12 months?	Fetal death 3	☐Ectopic pregnancy			23d. Date of delivery Month Day Year		
by the a		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at til 9☐Unknown	me of death 5	Other (specify)				
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Records e law requires has been sign ge 2 should be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
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	-						24a. Was an autopsy	24b. Were auto	opsy findings available empletion of cause of
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certificate	25. \	Was case referred to medica examiner?	Hospital:		100		th (Check only one)		
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the t	5 2	2 Accident invest 3 Suicide 6 Could	81910	5 12:40	<u> </u>	/\		on Newton	
		4 Homicide determ	nined building, etc.	y - At home, farm, st (Specify) *	reet, factory, office	,	City or Town,	State) 6017 E	Eastern Ave
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To the Hospital or Al within 24 hours affect of To the Funeral Direct completely filled in by Medical Certiff	29a. 29b.	(Check only one) Signature and title of certifies	I Examinar: On the basis of and manner state er L HOUGA n who completed cause of deal HAU HAW MA	od. WWA ath (Item 23a) (Type 111 Pe	O.C.	M.E.	Au		

State of Maryland / Department of Health and Mental Hygien 2005 28676 State Registrar AMEND Item #5 Per FH G847 9 Sertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 23, Julia Jeanette Smith 2005 6:18 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4631 Araby Church Road Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 11, 10 Frederick 5. Social Security Number 226-16-1036 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1□ M 2₩F Yrs. 81 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4631 Araby Church Road 21704 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John William Macklev Mary Selina Menchey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Timothy E. Smith/Son 5120 Jefferson Pike, Frederick, Maryland 21704 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Mt. Confidence of the color Aug. 27, 2005 Frederick, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Keeney and Basford Funeral Home 23a. Part 1. Enter the disease, or complications that passed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate shock, or heart failure. List only one cause on inch line.

106 Fast Church Street. Frederick MD 21701
Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Chronic obstructive pulmonary disease disease or condition resulting in death) /Medical Examiner tobacco Smokine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit been signed by the attending physician and should be deteched for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown uned cancer not confirmed by this certificate has been ongestive hear 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed 25. Was case referred to medical examiner? Kona 1 ☐ Yes 2 No 1 Yes After this certific funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation s after death the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification completed cause of death (Item 23a) (Type, Print) 198 Momas Johnson Dr #200 Frederick, MD 21702 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parti Registrar SEP 0 1 2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Year PENNY GLERUM SPICER 09334 23205 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner if Under 1 Year | If Under 24 Hrs. <u>Regional Medical Center</u> DIDSULA WILDMILL 5. Social Security Number 222-58-3217 8. Date of Birth (Month, Day, Year) AUG 11 1959 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF DELAWARE 46 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f show their roust be notified at 1 ☐ Yes 2 → No Directo DELAWARE SUSSEX LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30719 CYPRESS LANE 19956 USA Funeral 12. Was Decedent Ever in U.S. Armed Forcen? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ♣ Divorced Specify: WHITE ģ the Medicul Exam natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) SALES REPRESENTATIVE POULTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be R. RAYMOND GLERUM NINA WILKERSON 19a. Informant's Name/Relationship (Type, Print)
PAUL E. DOWNES / B 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 311 WHITE HERON COURT, OCEAN CITY, MD 21842 permit. Pages 1 and 2...
Depertment of Heaith ar Important: If Item 27 is any Injury or other traus. **BROTHER** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SUMMIT CREMATIONSVCS 8/25/05 4 ☐ Donation 5 ☐ Other (Specify) WYOMING. DE 21. Signature/of Funeral Service Licensee SHORT FUNERALF SERVICES INC. m. 609 E MKT ST, GEORGETOWN, DE 19947 Thort 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metostolic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) o ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 : autopsy performed 2□ No 2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 00056776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 145 EAST CARROLL ST. SALISBURY, MD. LINTON. 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 1 2005

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Cásandra J. Sampler Amend item#1, perME, G847, 9/1/05 TT State of Maryland / Department of Health and Mental Hygiene 05-05406 NJM Certificate of Death Reg. No. 2005 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Cassandra Janine Sampier 2005 August 1348 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4713 Tuscarora Rd Point of Rocks Frederick If Under 1 Year If Under 24 Hrs. Months, Days Hours Min. Aug. 18, 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1973 10 M 20 F 220-78-3300 31 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Washington Hagerstown **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18225 Eliason Way 21742 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 21215-0036 SpecifWhite 1 ☐ Yes 2 ☒ No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages t and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other to any Injury or other traumatic event. In once. Customer Service Rep. Lumber Company Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roger G. LeBlanc Mary Anne Swaim ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Swaim/ Mother 18825 Eliason Way, Hagerstown, MD 20742 Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) August 15 1X□ Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 4 ☐Donation 5 ☐ Other (Specify) 2005 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muetalle In /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence (Specify) Scene ဥ XXYes 2 □ No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver in a motor vehicle accident 1 Natural 5 Pending investigation 8/10/0 efter death. f Director: Af d in by the fur 1 Yes 2 No 2 Accident
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4713 TUSCUSTORA Rd 4 Homicide within 24 hours e To the Funeref 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 OCME August, 11, 2005

State Registrar

8 AUG

31. Date filed (Month, Day, Year)

2005

3. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

amend item#21, perFil, G84/9/2/05 TT State of Maryland / Department of Health and Mental Hygiene 0.05

28679 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Year August 6, **Physician** Jay Lincoln Smith 5:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Mount Airy
If Under 1 Year | If Under 24 Hrs. Frederick Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1₩ 2□F **Director** Yrs 333-01-6750 87 12, 1918 Feb. Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Exertities must be notified at 1 ☐ Yes 2 ☑ No Maryland Frederick <u>Frederick</u> Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 8388 Buckeye Court 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filad within 72 hours after nent of Health and Mentat Hygiena. int: If itam 27 Is marked othar than "natural", or Ita 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Smith Helen Bull P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8388 Buckeye Ct. Frederick, MD 21702 Sandra Smith-Gill / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. 12, 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Dapartment o Important: If any injury or once. Alexanandria, VA Metropolitan Crematory 2005 22. Name and Address of Facility Advent Funeral & Cremation Services 21. Signature of Funeral Service Licensee M00982 D. Blair Adams perDVR 7211 Lee Highway Falls Church, VA 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Congestive Heart Failure years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed the burial-transit ding physician and resulting in death) Last Due to (or as a consequence of) 神 21 Division of Vital Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant signad by the atter d be detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Arrhythmia, Hypertension, Diabetes 2

No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 1 ☐ Yes 2 No 200 No or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 ▼ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To tha Funaral Diractor: , completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D00610+ who completed cause of death (Item 23a) (Type, Print) Solarex a Frederick Mi) 10 0 32. Raistrar's Signature 31. Date filed (Month, Dav. Year) State Come Registrar

State of Maryland / Department of Health and Mental Hygiene 200528680 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year Lola Regina Sangston 4:10 a M August 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕃 F Director 215-46-0944 Aug. 21, 1913 91 Maryland Usual Residence of Decedent the Maryland 10b. Count 10c. City, Town or Location ahow 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2 ☑ No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ŏ rthan "natural", or Itame 23a or the Medical Examiner must be 6411 Crane Terrace 20817 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after I □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X XNo Specify Specify: White þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mantal hy Important: If Item 27 is marked oth any injuy or other traumatic avantonce. 18 Mother's Name (First Middle Maiden Sumame) Frank Beauregard Christie 2 Lola Amanda Nikirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Crane Terrace, Bethesda, Maryland 20817 Beverly Sangston/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) August 19, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 Donation 5 NOther (Specify) Entombment 2005 Silver Spring, Maryland 22 Name and Address of Facility Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 Acres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Pleural Effusion Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Clinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗷 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification; or Attending Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: 2 Accident investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62949 August 17, 2005 0 30. Name and address person who conveted cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland Natasha Haag, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 2005 8

Songston, lola

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Rachel SILK 5, /Medical 2005 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hebrew Home of Greater Washington Rockville
If Under 1 Year If Under 24 Hrs. Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 27 ☑ F Days Hours 111-05-5680 91 Director 22. 1914 New York Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, the Medical Examinat must be notified at annea. 10d. Inside City Limits 1 Yes 27 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 5410 Wehawken Road 20816 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 ☐Widowed 4 ☐ Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Food and Drug Elementary/Secondary (0-12) College (1-4or 5+) Chemist Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isador Sclar Hannah (unknown) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julian Silk, Son 2189 Stratton Drive, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

¹ 4 Donation 5 Other (Specify) <u>Judean Memorial Gardens</u> Olney, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part the disease, or complications that caused the death. Do not enter the shoot or heart failure. List only one cause on each line. St. NW. Washington, PC Interval Between Onset and Death Immediate Cause (Final **Physician** Varian disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifie Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035/68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaiser Permanente Benson 501 N. Frederick Ave., Gaithersburg, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 18 2005 AUG Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28682 Certificate of Death

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and	×		

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "neturel", or Iteme 23e or 28e-f ehov my Injury or other traumatic event, Ira Medical Examinating the Lottified at ORGE.

Baltimore, Maryland 21215-0036

11 AUGUST 2005

Box 68760,

P.0.

Smothers, John E. Thistory Division of Vital Records,

Physician /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed

	Registrar					runça	COIL	Jeani			10g. No.		
	1. Decedent's Name	e (First, Middl	e, Last)							2. Date of Dea Month	nth Day	Yeer	3. Time of Death
an cal	JUHN	E	5	MOTHE	25					03	11	2005	4: 24 PM
ier		If not institution	n, give street and nu			4b. City,	Town, or	Location of	Death		4c. Coun	ty of Deeth	
	SUBUR	BAN	HOSPIT	17L				SOA		no	mon		MERY
	5. Social Security N		6. Sex 1 ★ M 2 F	7. Age (In yı	s. last birthday	If Unde Months	r 1 Year Days	If Under 2 Hours	Hrs. Min.	8. Dete of Birt (Month, De)	h /, Yeer)	9. Birth	plece (State or Foreign ntry)
	340-24-5		12M 28F		72_Yrs.					11/07	132	Illi	inois
	Usuel Residence of	10b, County		10c.	City, Town or L	ocation							10d. Inside City Limits
ō	Maryland	1	gomery		Bethe								1 ☐ Yes 2 💆 No
Director	10e. Street and Nu		.gomery		106 C116		p Code				10g. Citizen o	f What Cou	intry?
		Roxbury	Drive				0814					JSA	
Funeral	11. Marital Status			edent Ever in	US 13			ispanic Orig	in? (Spe	ecify Yes or No		ace - Ameri	can Indian.
S	1 Never Marr	ried 2 XMar	Armed F			Il Yes, spe	city Cuba	in, Mexican,	Puerto	Rican, etc.)	BI	ack, White,	, etc.
þ	3 Widowed			oates: 195	8-63	1 🗆 Yes	2 X No	Specify:			Spec	ity: Whi	te
Completed			nt's Education		16a Dece	edent's Usu	al Occup	ation	-4mls:		16b. Kind of	Business/Ir	ndustry
pie	Elementary/Seco		st grade completed) (1-4or 5+)	ife.	DO NOT	ise retired	during most	or works	ing			
E O			5+	,	Cli	nical	Psy	cholog	gist		Psyc	holog	У
Be	17. Father's Name		-					18. Mother	's Name	First, Middle,	Maiden Suma	ame)	
0	Frank A	lbert	Smothers					Doro	othe	a Ann C	ulkin		
1	19a. Informant's N									al Route Numbe			p Code)
1.	Barbara	Smoth	ers/ Wife					Drive		ethesda			
	20a. Method of Dis	*	3 Removal from	- 1	 Place of Disp cemetery, cre 	osition (Na matory or	me of other plac	(a)		ust 17	20c. Location	n - City or T	own, State
	° 4 □ Donation			G	ate of He		-	ry	2	005			ng, Maryland
	21. Signature of Fi	uneral Service	Licenses		\mathbf{F}^{ϵ}	ranci	nd Addre	sset Facility	ns	Funeral	Home	Inc	, MD 20901
	Cru	1	Deerle	7	2	oo on	iver	sity E	lvd	, W, Si	lver S	pring	, MD 20901
	23a. Parti. Enter shock, or hea	th disease, d all failure. Juls	complications that tonly one cause on	caused the de each line.	eath. Do not er	nter the mo	de of dyin	ig, such as c	ardiac c	or respiratory as	rest,		Approximate Interval Between
	Immediate Cause disease or condition	on	R	epron	COL A	Bloc	WIN	the A	ORI	DC AN	rever.	SM	Onset and Death
	resulting in death)		Due to	(or as a cons	sequence of):					oc An			
I.	Sequentially list co	onditions,				BNO	· V	15 Cell	AX	0750	915E		YEAKS
Examiner	Sequentially list co if any, leading to it cause. Enter Und Cause (Disease or	mmediate erlying	Due to	o (or as a cons	sequence of):								•
Каш	that initiated event resulting in death)	S	c	o (or as a cons	sequence of):								
				(0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
an/Medical			d										
/Me	IF FEMALE:		23c. If yes, o	utcome of pre	gnancy						23d [Date of deliv	/ADV
clan	23b. Was deceder in the past 12	2 months?	1 Live	birth 2 F	etal death 3	☐Ectopic p	oregnancy	1				Month	Day Year
by Physici	1 ☐ Yes 2 9 ☐ Unknow		9□ Unk				,, _						
P P	Part II. Other signi	ificant condit	ions contributing to	death but not	resulting in the	underlying	cause giv	en in Part I.		23e. Did t	obacco use co	ontribute to	the cause of death?
d D	l'									10	res 2□No	3 🗌 Pro	bably 4 Onknown
ete										24a. Was	an 241	. Were aut	opsy findings available
Completed									-		med?	prior to death?	opsy findings available ompletion of cause of
ပိ	25. Was case refe	erred to medic	al					26 Place	of Death	1 Yes	2 No	1 🗌 Yes	2L No
ToB	examiner?		Hospital:	npatient 2	ER/Outpatio	ent 3 🗆 🗅	Oth	or		me 5 Resid		ther (Spec	ity)
12	27. Manner of Dea		28a. Dat	e of Injury onth, Day Year			28c. Injur			28d. Describe			,,
atio	1 Natural 2 Accident	5 Pendi inves	ing (MC	inin, Day real	r) Injury	м		Yes 2 □ N	No				
ij	3 Suicide	6 ☐ Could	mined 200. Fla	ce of Injury - A	t home, farm, s	treet, facto	ry, office			281. Location (- City or Tox	Street and Nu	mber or Rui	ral Route Number,
Certification:	4 [] / fortileide		Dui	dirig, etc. (Spi	ouiy/					Only or 10	wii, Olato)		
ai	29a. Certifier (Check only		ing Physician: To t										
Medical	one)	2 Medica	I Examiner: On the and ma	nner stated	ination and/or	investigatio	n, in my c	pinion, deat	n occur	red at the time,			
Σ	29b. Signature	d title of certifi	er 7	-/				e number			29d. Date sig	ned (Month	. Dey, Year)
	Li	chono	Velin	2Km			MI	428	365		8-	11-0	5
			n who completed ca		Item 23a) (Type								
			Teinberg,	M. D.		scons	sin A	lvenue	, #2	2, Beth	esda,MD	2081	. 4
tate	31. Date liled (Mo	onth, Day, Yea	2005	Registrar's Si	ignature	ante							
trar	M	JUG IC	LUUJ P	16145	15 15	SEL APON							

State Registrar

		•	For State Registrar	State of Maryland / De	epartment of F Certificate of	lealth and M Death	lental Hygi Re	iene 2005	28683
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Floyd E. Stolars	ki, Sr.			2. Date of Death Month August	16, 2005	3. Time of Death 12:05P. M
ı	Examin		4a. Facility Name (If not institution, give st Laurel Regional Ho		Laure	r Location of Death		4c. County of Death Prince G	
	Funeral Director		233-42-3340	M 2□F 7. Age (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Dec. 29,	1928 West	place (State or Foreign ntry) Virginia
	daryland f show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge	orge's Beltsvi					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the has or 28a-i	Direct	10e. Street and Number 4821 Lexington Ave	nue	10f. Zip Code 20705			og. Citizen of What Cou United Stat	-
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once.	by Funeral Director			13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	vithin 72 hounder.	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Outline (A. Aug E.)	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire Ctrician	pation during most of work d)		16b. Kind of Business/II Electrical	
	d be filed v ental Hygie kad other t c evant, the	To Be Co	17. Father's Name (First, Middle, Last) Louis	Stolarski		18. Mother's Name Pauline	e (First, Middle, M	faiden Sumame)	Plucus
Maryland	nd 2 shou alth and M 27 is mar	-	19a. Informant's Name/Relationship (Type Susan Stolarski –d		lailing Address (Street	and Number or Run n Avenue	al Route Number, Beltsvil	City or Town, State, Zi le, Maryla	o Code) nd 20705
Baltimore,	Pages 1 a nent of Hee int: If Item iry or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	isposition (Name of crematory or other plan d Veterans	ce)		20c. Location - City or T 105 Cheltenl	own, State nam, Maryland
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service License	Juomas ,	22. Name and Addre Donald V. 4400 Powde	r Mill Ro	ad Belts	ville. Mar	yland 20705
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death. Do not a cause on each line. Esophageal Cano Due to (or as a consequence of)	er	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
90,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) Due to (or as a consequence of)					
.O. Box 68760,	The law requires that the death certificate are has been signed by the attending physi page 2 should be detached for use as the l	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of delive Month	rery Day Year
S, O	luires that in signed by	by	Part II. Other significant conditions con Diabetes; GERD	tributing to death but not resulting in th	ne underlying cause giv	ven in Part I.		acco use contribute to	the cause of death?
Record	The law requirence has been si bage 2 should l	Completed					24a. Was an autops perform	y prior to co	opsy findings available ompletion of cause of
on of Vital	hysician: his certifica I director.	To Be	27. Manner of Death 1 XNatural 5 Pending	ospital: 1 X Inpatient 2 ☐ ER/Outp: 28a. Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury		n <i>(Check only one</i> me 5□ Reside	A	fy)
Division	or Atten after deat Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Sti City or Town	reet and Number or Rui , State)	al Route Number,
-	To the Hospital or Attending Pwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funera	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, oner: On the basis of examination and/or and manner stated.	death occurred at the ti or investigation, in my o	me, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
)	Vaithir Comp	Me	29b. Signature and title of certifier	Here	29c. Licens	5323		9d. Date signed (Month)	Day, Year)
	`		30. Name and address of person who con Darryl Hill, M.D.	13635 Baltimore A	venue Laur)7	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 18 20	32 degistrar's Signature	Sparte				

State of Maryland / Department of Health and Mental Hygiene 200528684 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 0245AM :10 Garcia perrand 2005 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sa At the 115 buru Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□ F Months Days 582-42-8378 Director 10/28/1928 Puerto Rico Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumetic event, the Medical Extending resident residents. 1XYes 2 □ No Maryland Funeral Director Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 728 Waverly Drive 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other traumetic event, the Mexical Examina 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 XYes 2□ No Specify: Puerto Rican þ Specify: Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cemetery Assistant Mt. Carmel Cemetery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ramon Garcia Catalina Serrano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia Garcia-Serrano/wife 728 Waverly Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory 8/16/05 ¹ 4 □ Donation 5 □ Other (Specify) Hebron, MD Gardens 22. Name and Address of Facility Holloway Funeral Home Professional Association unature of Funcial Service Licensee CFSP Wampoor 501 Snow Hill Rd., Salisbury, MD 21804 TANKS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (ancer Physician Metastatic Colon GMON/18 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ZNO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3□ DOA Sich 28a. Date of Injury (Month, Day Year) 27. Mayner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\sum \) Homicide To the Hospital within 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 126278 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAUD COUNTL MD 31. Date filod (Month gistrar's Signature State Registrar

			F (4	_	-		nd / Dep					•		e Legible.	
		•	1 - State Registrar				•	rtificate					_	2005	28685
	Physici	an	1. Decedent's Name (First, Mi Kenneth Taylo		-							2. Date of De Month	Da	ay Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institu		reet and num	her)		4b. City. T	Fown, or	Location o	of Death	August	$\overline{}$	2005 c. County of Dea	5:40 P M
	Examir	ier	Southern Mary	_			ter		nton					rince Ge	
	Funeral		5. Social Security Number	6. Sex	7	. Age (In yr	s. last birthday) Yrs.	If Under		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year		thplace (State or Foreign ountry)
	Director		216-44-9787 Usual Residence of Decedent	X	M 2□F	91	Yrs.					March	14	1914 New	Jersey
	show		10a. State 10b. Cou	,			City, Town or L					-			10d. Inside City Limits
	Ba-f s	Funeral Director		ce Geo	orge's	Up	per Mar								1 ☐ Yes 2 ☑ No
	with the or 2	DI.	10e. Street and Number 9910 Rosaryvi	110 D	224			10f. Zip (^{Code} 2077	72			10g. C	itizen of What Co USA	ountry?
	death	nera	11. Marital Status		2. Was Deced	lent Ever in	U.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)	>-	14. Race - Ami	
36	ours after death with the Maryla rai', or Itams 23a or 28a-f show Examinar must be notified at	by Fu	1 Never Married 2 N		1 Tyes 2	es:WW I	т	1 Yes 2		Specify:	, rueito	rican, etc.)		Black, Whi	hite
215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show the Madical Examiner must be notitled at	ed b	3 Widowed 4 □ Divor	dent's Educa		IOS: NANA T	I 16a Door	doet'e Heusl	L Cooupa	ation			16b.	Kind of Business	
215	hin 72 9. 9n. 'n8 Medis	Completed	(Specify only hig Elementary/Secondary (0-1	hest grade	completed) College (1-	4or 5+)	(Give	kind of work DO NOT use	k done d e retired)	luring most)	t of worki	ing			,
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Maryland	ould be fi Mental H arkad ot atic evar) Be	17. Father's Name (First, Midd Alfred J. Tay									,		ridge Ta	vlor
ary	2 should and Men is marka sumatic	၉	19a. Informant's Name/Relati		e, Print)		19b. Maili	ng Address	(Street a					or Town, State,	
	s 1 and 2 should if Health and Men itam 27 is marks othar traumatic		Diane O. Duva	11 (N:	iece)					Farn		-		Maryland	
altimore,	0 0		20a. Method of Disposition 1 1 □ By 1 2 □ Cremati	on 3 □Re	moval from S		Place of Disponential Company	matory or oth	her place	9)		OF		ocation · City or	Town, State
Itim	permit. Pag Department Important: I any Injury o		4 ☐ Condition 5 ☐ Othe 21. Signature of Juneral Serv		?	St	Thomas	2. Name and			3–23-			oom, MD	
Ba	Depa Impo any le		Volunt?		MOO	<u>)17</u> 3					EDE			eral Ser	
	WE G		2 7 11. Enter the disease shock, or heart failure.	, or complication	ations that ca	used the de ch line.								3.7 110 2	Approximate Interval Between
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	/Medical Examiner		resulting in death)		Due to (c	ras a cons	equence of):	vate	261	Pu	ן מוננס	unwie			12 maile
	K	Je.	Sequentially list conditions, if any, leading to immediate	b.	Due to (c	r as a cons	equence of).	Vari		0	.,				2 2 7760 37
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 .	Cou	yerr	ie l	least	_	Pau	luv	æ			<2 moul
,092	ite be executed ysician and ne burial-transit	cal Ex	resulting in death) Last		Parto (o	r as a con	equence of):	Atric	l	Fi	hu	uo vier ve leet is	n		<2 mouls
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Xo	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, outc	ome of preg th 2 □ Fe		∃Ectopic pre	ananav					23d. Date of de	*
O. B	e deat	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown			nt at time of		Other (spe						Month	Day Year
P.0	res that the de signed by the a be detached f		Part II. Other significant con-	ditions cont	ributing to dea	ath but not re	sulting in the u	inderlying ca	iuse aive	n in Part I.		23e. Did 1	obacco	use contribute to	the cause of death?
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O	aw requir s been si 2 should	plete			ľ							24a. Was		24b. Were a	utopsy findings available
- Be	The lav ate has page 2	Completed								-		auto perfo 1 Yes	rmed?	death?	completion of cause of 2 No
Vital	ysician: The iis certificate director, pag	Be	25. Was case referred to med examiner?	_	spital:				. Othe			(Check only			
of	Phys r this aral dir	To To	1 ☐ Yes 2. No 27. Manner of Death	110	28a. Date of		☐ ER/Outpatie 28b. Time o	-	Bc. Injury	at	-	me 5 Resi 28d. Describe		6 ☐Other (Spe	ocify)
ion	nding Phy ath. r: After thi	atior	1 Natural 5 Per Per 2 Accident	nding estigation	(Month	, Day Year)	Injury	М	Work	k? Yes 2 □ N	No				
Division	or Attandatter death Diractor: in by the	Certification:		uld not be ermined	28e. Place o buildin	of Injury · At g, etc. (Spe	home, farm, st	reet, factory,	office			28f. Location (City or To			ural Route Number,
Q	pital o		29a. Certifier 15 Certi	lvina Physi	cian: To the l	pest of my k	nowledge deal	h coourad a	at the tim	o data and	d place	and due to the	001100/0	s) and manner as	catatod
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	(Check only 2 Medi	cal Examin	er: On the ba	sis of exami	nation and/or in	vestigation,	in my op	pinion, deat	th occurr	ed at the time,	date ar	nd place, and due	e to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of cer	tifier /	A	1 -	14.0	29c.	License	number	a	٨	29d. Da	ate signed (Mont	H Pay, Year)
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1	h		30 Name and address of per	4	upleted cause		em 23a) (Type W O	Print)	00	per	·N	lavella	OV	o mo	2005
	Sta	ate	31. Date filed (Month, Day, Y	ear)	32 Ba	strar's Sig	nature							6	
	Regist	rar	AUG	1820	U5	Meser	BA	porte	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 5:00 Russell Turner August 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Genesis Eldercare- Layhill Center Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year April 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1920 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Utah Director 528-03-4137 85 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland nent of Heelih and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or itame 23s or 28e-1 ehow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itame 23a or 28e-f ehow treumatic event, the Modical Examinar must be notified at Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1800 Gayfield Drive 20906 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Russell Turner Flora Leigh Block 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 f Eleanor Elizabeth Rangan/ Daughter 15300 Bushy Park Rd,. Woodbine, MD 21797 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State August 16 Metropolitan Crematory injury * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. CI 500 University Blvd, W. Silver Spring, MD_20901 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Олкломл 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Pneumonia, Depression Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Yes 2 XNo Hospitel or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4^K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitef within 24 hours a To the Funerel D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D34472 August 15, 2005 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 39 Registrar's Signature Lynne Diggs, M 31. Date filed (Month, Day, Year) M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895

DHMH 17 Rev 1/2001

Registrar

18

AUG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene 28687 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Paula Truitt AUGUST 12, 2005 5:57 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO CO If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 44 Yrs. Director 212-80-8315 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Item 27 is marked other then "natural", or itame 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 11XYes 2□No **Funeral Director** MD Worcester Snow Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumest-any es. 212-A South Ross Street 21863 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 157 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Prevention Specialist Health Department 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas P. Tritt, Sr. Elsie Dennis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erica M. Truitt/Daughter 212-A South Ross St. Snow Hill, MD 21863 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition St. cometary, crematory or other place) St. dames Holiness Church Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/20205 Snow Hill 22. Name and Address of Facility
Lewis, N. Watson, Funeral Ho
1618 West Road Salisbury, 21. Signature of Euneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a BLATERAL PULMONARY THROMBUETBOUSH /Medical Due to (or as a consequence of): Examiner DEEP VENOVS THROMBOSIS RIGHT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Be Completed OBESITY DILATED CARDIOMEGALY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death? 2 No 18 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner's Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 □ No 2 ER/Outpatient 3X DOA t) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending eftar death. 1 🗌 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 24 hours e 22n Cartifion 1 Genthying Physician: To the best of my knowledge, death occurred at the time, date and place, and dire to the causale) and manner as stated. Medical within 24 hou To the Fune completely fi 2XXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME AUGUST 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD 111 PENN STREET, BALTIMORE, MARYLAND, 21201

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) AUG 1 7 2005

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32. Pygistrar's Signature

05-05526 Orlando RJD

ando	Whor	ns	For	State of Maryland	Depa	rtment of H	ealth and M			
			1 - State Registrar		Cer	tificate of l	Death		eg. No.	
	Physici		1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day	3. Time of Death
	/Medic		ORLANDO	WHORMS				August	T	005 1804 P.™
	Examin		4a. Facility Name (If not institution, give			-	Location of Death		4c. County	
1			Prince Georges Ho	*	h: 45 4 1	Chever	Ly If Under 24 Hrs.			ce Georges
	Funeral		5. Social Security Number 6. Se	KM 2FF	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day June 26	Year)	9. Birthplace (State or Foreigr Country) Jamaica
	Director		577-29-1445 Usual Residence of Decedent	26				June 20	13/3	Jamarca
puel	A H		10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
Z	12	ğ	MD Prince G	eorge's New	a Car	rollton				1 X Yes 2 □ No
ģ	128	Je C	10e. Street and Number			10f. Zip Code			l 0g. Citizen of \	What Country?
5-0036	38.0	by Funeral Director	6108 86th Avenue			2078	34		U.S.A.	
de a d	E 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of Hi	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. Rac	e - American Indian,
9	or the	Z	1 Narried 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 Tes, specify Cuba 1 ☐ Yes 2 【※No	Specify:	nican, etc.)		ck, White, etc.
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2 2	Hygiene. other then	ပိ	12th 17. Father's Name (First, Middle, Last)			Cater	18. Mother's Name	e /First Middle		
Maryland	Mental harked of	Be	Samuel Whorms				Jennife		walden obman	10)
ary!	d Me Traff	7	19a, Informant's Name/Relationship (T	roe Print)	9h Mailin	na Address (Street :	and Number or Run		r City or Town	State Zin Code
Ma	th and 7 is mu	1	Jennifer Powell							yland 20784
Baltimore,	it of He or oth		20a. Method of Disposition 1 Surial 2 Cremation 3	20b. Place ceme	of Dispo	sition (Name of natory or other place		Date	20c. Location -	City or Town, State
Baltin	Departmen Important: any injury		4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens		22	. Name and Addres	ss of Facility J.	B. Jen	kins Fu	neral Home yland 20785
	hysician /Medical xaminer		23a. Parti. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. In ecause on each line. a. Mutple I Due to (or as a consequent	njur	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
60,	ysicien and e burial-transit	Examiner	Sequentially list conditions, if any, leading to limited actions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequen						
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. Box 687	atter for u	Completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de 4□Pregnant at time of death	ath 3□	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
P.0	ed by the detached	hys	9 ☐ Unknown	9□ Unknown						
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of Vital Records,	has b	ompiet						24a. Was a autop perfor	sy med?	Were autopsy findings available prior to completion of cause of death? 1 XYes 2 \sum No
tal	certificate	0	25. Was case referred to medical		-		26. Place of Deat			100 2010
	2 5 2 5	TOB	examiner? 1 ☑Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐XER	Outpatier	nt 3 DOA Oth	00	me 5 Resid		ner (Specify)
o uo	th. :: After this s funeral di		27. Manner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident investigation	(Month, Day Year)	b. Time of Injury	Wor	y at		ow injury occur	red operator of mater-
Division	to the Trospies of Attending Frighting Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined			reet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State) 42	per or Rural Route Number,
	24 hours Funeral etely filler	Medical C	29a. Certifier 1☐ Certifying Phy (Check only one) 2 Medical Exam	vsicien: To the best of my knowle iner: On the basis of examination and manner stated.	dge, deatl and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, o	ause(s) and made and place,	anner as stated. and due to the cause(s)
	Within To the compl	Me	29b. Signature and title of certifier			29c. Licens		:	29d. Date signe August	16, 2005

State Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore Maryland 21201

State of Maryland / Department of Health and Mental Hygien20051 - For State Registrar 28689 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** Sharon C. Williams _15**,**2005 August 4:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2707 Keating Street Temple Hills Prince George If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 22, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 577-64-4857 58 **Director** 1946 Washington, DC Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits th and Mantal Hygiene. ?7 is marked other then "neturel", or leans 23s or 28s-f show traumatic event, the Medical Examinar must be nutified at 1 √ Yes 2 No Director Maryland Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 Keating Street 20748 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: Black 1 ☐ Yes 2 X No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Nurse Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Harry Carrol1 Madeline Chew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Importent: If Item 27 Is any injury or other trau once. Kim F. Williams-Adams 2707 Keating St. Temple Hills, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Aug. 19, 2005 Landover, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike wa Forestville, MD. 20747 Part1. Enter the disease of emplications that caused the desible shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit and physician by Physician/Medical use as IF FEMALE. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death for in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown as been signal 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2□ No 1 ☐ Yes 1 Yes 2 X No or Attending Physician: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral C Hospitel Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 20015558 August 17, 2005 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Sukumaran Aryangat, M.D. 3308 Perry Street, Mount Rainier, MD. 31. Date filed (Month, Day, Year) AUG 1 8 2005 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

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-3			Registrar ATELOTED - PEL Decedent's Name (First, Middle, III)		0-2-	03000	incate of t	Jean	2. Date	e of Death	200	3. Time o	Death
	Physicia /Medid		JOYCI		WATTS	5			AI	IG 11	2005	3:00	PM
	Examin	er	4a. Facility Name (If not institution, s NATIONAL NAVA			ER	4b. City, Town, or BET1	· Location of HESDA	Death	40	c. County of E	GOMERY	
	Funeral			. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date	e of Birth	9	Birthplace (State Country) Wash.,	or Foreign
	Director		Usual Residence of Decedent	1□ M 2\ XF	6	6 Yrs.			Dec	nth, Day, Year	1938	Wash.,	DC
	yland yland		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside C	
	Ba-fs	Director		Arundel			T	Odent	on	10. 0	22	21	2 □ No
	with to	Dir	10e. Street and Number 703 Harvest	Run Drive			10f. Zip Code	211	.13	10g. C	itizen of Wha Unit	ed State:	s
	filed within 72 hours after death with the Maryland Hygiene thar than "natural", or Items 23a or 28a-f show that the Medical Examinar must be notified at	Funeral	11. Marital Status	12 Was Decede	ent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi n. Mexican.	in? (Specify Ye Puerto Rican, e	s or No-		American Indian, Vhite, etc.	
36	s after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 1 Yes 2 If Yes, Give Year or Date			1 □ Yes 2 No	Specify:		,	Specify:	African	
21215-0036	2 hour	ted t	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation	of working	16b. I	Kind of Busin	American ess/Industry	
2	nthin 7 ne. han "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	Social V	1)			Cove	rnment	
d 2	filed v Hygie othar t		17. Father's Name (First, Middle, La				SOCIAL		's Name (First,	Middle, Maide		I IImcii c	
/lan	Mental Mental rrkad o	To Be	Joseph Bold	len					Eva	Tucks	on		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic avant, the Medical Examinat must be notified at ance.		19a. Informant's Name/Relationship			19b. Mailii	Address (Street a			•		te, Zip Code) 21113	
<u>е</u>	f Healt fem 2 other		Terrie Hawkins 20a. Method of Disposition		20b. P	lace of Dispo	698 Hayme esition (Name of matory or other place	1	Date	-		or Town, State	
Baltimore,	Pages ment of H ant: If its ury or of		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	icify)	ate	-	Memorial]		3/17/200)5 L	andove	r, MD	
3alt	permit. Departr Importa any inju		21. Signature of Fulle al Service Lie	censee	A -		2. Name and Addres	s of Facility	Stewar	t Fune			
	00200		23a. Part1. Enter the disease, or co	omplications that cau	sed the deat	h. Do not ent	4001 Bent er the mode of dyin				., DC	Approxima	
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8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):							
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Вох	death certific e attending p d for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Feta	death 3	Ectopic pregnancy			1	23d. Date of Month		Year
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s, P.		by Ph	Part II. Other significant condition	s contributing to deal	h but not res	ulting in the u	nderlying cause give	en in Part I.	23	e. Did tobacco	use contribu	te to the cause of	death?
ord	w requires been sign should be								- Mag	1 ☐ Yes 2	2 XN0 3	Probably 4 🗌	Unknown
Sec	e law has b je 2 sl	ompleted							24:	a. Was an autopsy performed?	prior	e autopsy findings to completion of a h?	available cause of
ta	icien: Th certificate rector, pag	e C	25. Was case referred to medical					26. Place	of Death (Chec	Yes 2X N	0 10	Yes 2 No	
of Vital Record	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 🔀 Inp		ER/Outpatie		4 🗆 1401.	sing Home 5			Specify)	
	on.	tlon:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month,	Day Year)	28b. Time o Injury	Wor	yat k? Yes 2.⊟N		escribe how inju	ary occurred		
Division	r Attanding er death. ractor: After by the fune	ertification:	3 Suicide 6 Could no	ot be 28e. Place of	Injury - At he etc. (Specif	ome, farm, st	reet, factory, office		28f. Loc City	cation (Street a	nd Number o	r Rural Route Nun	nber,
ō	• Hospital or Attandi 24 hours after death • Funaral Diractor: A etely filled in by the fo	O	Y Caritain		72		h						
	To the Hospit within 24 hours To tha Funara completely fille	dical		Physician: To the be xaminer: On the bas and manne	is of examina								s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	7.			29c. Licens	e number				fonth, Day, Year)	
•			jul	/	Th	W =	Annual Control	463A (The second secon			2 - 200	S
P	- (5)		AARON HOLLEY	capt MC	of death (Iter USA	n 23a) (Type,			MD 2088		CENTE	K	
* -	Sta		31. Date filed (Month, Day, Year) AUG 1 7 20	4.0.	1.4 - In Oliver	ature for							
18	Regist	rar	A00 1 1 20	NOT THE		17							

05-05652 Walter Wilson RJD

)	WIISO	•	State Unpend Item	State o 23a,pt.	f Marylar	nd / Depa 8a-f_{.O}e /	rtment of H	lealth and Death	Mental Hygi tas	ene g. No. 200	15 28691
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					2 Date of Death Month August	1	3. Time of Death
	/Medic Examir		Walter Raym 4a. Facility Name (If not institution, given 812 Phillips St	e street and nu	lson mber)		4b. City, Town, or Cambrid			4c. County of Dorches	eath
2	Funeral Director		5. Social Security Number 6.3	Sex,	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 9. E	Birthplace (State or Foreign Country) Shington, D.C.
9	pu .	_	Usual Residence of Decedent 10a. State 10b. County			ity, Town or Lo	cation		Dec. 10	1932 Wa	10d. Inside City Limits
	with the Ma a or 28a-f	Funeral Director	Maryland Dorches 10e. Street and Number			Cambri	10f. Zip Code			og. Citizen of What	1 XYes 2 □ No Country?
920	after deeth or items 23	ρ	812 Phillips Str 11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Amed Fo	2 □ No ve	l	21613 Was Decedent of H if Yes, specify Cube	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No-	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
21215-0036	I within 72 ho lene. r than "natur the Medical.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of w	orking	6b. Kind of Busine	ss/Industry
Maryland	D = 0 0	To Be C	17. Father's Name (First, Middle, Lass Joseph Eugene	Wilso	n			Mary	ame (First, Middle, M		
	1 and Health tem 27		19a. Informant's Name/Relationship Diana Wilson V 20a. Method of Disposition		20b.	812	Phillips sition (Name of	Street,	Gambridg Date		d 21613
Baltimore,	t. Pages rtment o rtant: if		t	(ty)	State	l. Vete	rans Cem. . Name and Addre	. 09–	02-2005	Hurlock,M	aryland
ä	Depa impo any ir		23a. Part1. Enter the disease or con	nolications that	caused the dea	th. Do not enti	Bennie Sn 524 Race	nith Fun Street,	eral Home Cambridg	e,Marylan	d 21613 Approximate
	Pnysician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Hero	each line.	alcohol	intoxica			o.,	Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions, if any, leaving to inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a conse						
8760,	cate be executed physician and the burial-transit	dicai Examin	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):					
P.O. Box 6	ne death certifi the attending I thed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live I	tcome of pregn birth 2 Pet nant at time of lown	aldeath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
	w requires thet the been signed by should be detact	ted by PI	Part II. Other significant conditions Cocaine use	contributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		to the cause of death? Probably 4 □Unknown
Vital Records,	. 60 17	Completed by							24a. Was ar autops perform 1 X Yes 2	/ prior	autopsy findings available to completion of cause of ? es 2 No
Division of Vit	tanding Physici death. tor: After this cer the funeral direct	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatic investigatic determined 3 Suicide 6 Could not determined	28a. Date 8-240 10010	of Injury 05 ^{ay Year)}		28c. Injur Wor	er: 4 🗆 Nursing	Home 5 Reside 28d. Describe ho 28f. Location (Str.	nce 6 Q Other (S w injury occurred	unk
Ö	To the Hospital or Al within 24 hours efter of To the Funeral Direc completely filled in by		29a. Certifier 1 Certifying P	four	d at ho	ome owledge, death	occurred at the tin	ne, date and plac	Cambridge ce, and due to the ca	e, Maryla use(s) and manner	as stated.
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	and mar	ner stated.	ation and/or in	29c. Licens	e number	curred at the time, da	nd Date signed (MC August 2)	
•			30. Name and address of person who	Leo- completed cau	1 1 15	m 23a) (Type,	Print) 111 P	enn Stre	eet, Balti	more Mary	/land 21201
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2	32. [ectrar's Sign	ature	St. 38				

RIS WII	YOON	1	- For Amend Item 26 Registrer	State of Ma per me G	arylan 847	id / Dep 9-12-0 Ce	artme 5 ta: rtifica	nt of H	lealth ar D <i>eath</i>	nd Me	ntal Hyg	iene g. No.	05	28	692
Phy	sician	_	Decedent's Name (First, Middle, Last)							2	Date of Deat Month AUG		Year	3. Time o	
/M	edical		Doris Wilson				45 65	T			AUG.	$22^{\text{Day}}, 200$		2205	Рм
Exa	miner		a. Facility Name (If not institution, give s SACRED HEART HOSE	ITAL			CU	MBERI				4c. County of			
Fune Direc			. Social Security Number 6. Sex 054-16-0338	7. Ag	e (In yrs.	last birthday) Yrs.		Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, eb 7		Cou	place (State intry) York	
yland		_	Oa. State 10b. County			ty, Town or Lo							T	10d. Inside (City Limits
Man a-fah	ctor		MD Allegar	ıy	Cu	mberl	and							1 Tyes	2 No
h with the	al Director	1	0e. Street and Number 15804 Downing S	St. SW				p Code 1502	2		1	0g. Citizen of W USA	hat Cou	intry?	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or itema 23a or 28a-1 ahow	by Funeral		1. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Armed Forces? 1 Yes 251 It Yes, Give Year or Dates:			Was Deci it Yes, sp 1 Yes		ispanic Origin, Mexican, I	n? (Specif Puerto Ric	y Yes or No- can, etc.)		. White		•
21215-0036 d within 72 hours af giene. pr then "naturel; or	Completed by	-	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+)	16a. Dece (Give life. Hous	kind of w DO NOT	ork done d use retired	ation during most o l)	of working		16b. Kind of Bus Home	siness/Ir	ndustry	
Maryland of the tiles the and Mental Hyger it is and Mental Hyger it is marked other the contractions of t	To Be C	1	7. Father's Name (First, Middle, Last) narles Franklin	Hoag							First, Middle, M	Maiden Sumame Hoag)		,
Mary		ſ	19a. Informant's Name/Relationship (7); Janice Felipa	Daugh	nter	19b. Maili 809	ng Addres Bish	s (Street :	and Number Valsh	or Rural F	Route Number Cumb	City or Town, Serland	state, Zij	D 215	02
Baltimore, N permit. Peges 1 and 1 Department of Health Important: If Item 27		2	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	0	Place of Disponentery, crest Law	matory or	other plac		Dat .ug 2		20c. Location - 0 LaVale	•		
Baltim permit. Pe Departmen Important:	Suc.		Signature of Fineral Service License	in		2:	2. Name a	nd Addres	s of Facility	Hafe	r Fun	eral S	erv	rice,	PA
8760, A cate be executed a cate be executed by sician end the brightness of the brig	Examiner		Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	,					eli no				
ords, P.O. Box 687 requires that the death certificate een signed by the eltending physical deaths described for use of the	Physician/Medical		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown	3c. It yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	al death 3	⊒Ectopic □ Other (s	pregnancy				23d. Date Mon		ery Day	Year
Cords, F w requires the been signed	ed by F		Part II. Other significant conditions cor	tributing to death b	ut not res	sulting in the u	nderlying	cause give	en in Part I.			es 2 □ No	bute to t		death? Unknown
Rec The law	. 0		25. Was case referred to medical						OC Phone	- Constitution	4.7	y pr ned? d !□No 1	ere auto ior to co th? Yes	opsy findings ompletion of 2 No	available cause of
of Vita Physician: this certific	To B	1	examiner?	ospital: 1 Alnpatie	ent 2][ER/Outpatie	nt 3 🗆 C	OA Oth	00		Check only on 5 ☐ Reside	nce 6 ∐Othe	r (Speci	fy)	
Division of Vital Lor Attending Physician: after death. Director: After this certifice	ation:		27. Manner of Death 1	28a. Date of Inju (Month, Da		28b. Time o Injury	f M	28c. Injun Wor		28		w injury occurre			
Division of the Hospital or Attending Phymithin 24 hours after death. To the Funeral Division of Attential Control of the Child Contro	Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At h c. (Specil	ome, farm, st fy)	reet, facto	ry, office		281	Location (St City or Town	reet and Numbe I, State)	r or Rur	al Route Nur	nber.
DIN DA Hospital or DA Hours afte DA Funeral Direction	Medical		29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemi	sicien: To the best ter: On the basis o and manner st	f examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tin	ne, date and pinion, death	place, and occurred	d due to the ca at the time, da	use(s) and man ate and place, a	ner as s	stated. to the cause(s)
To the within 2 To the			29b. Signature and title of certifier	U Lin	3.	an		O.	e number C.M.E		2	AUG.			
	P		30. Name and address of person who co	1. King	*			REET	,BALTI	MORE	,MARYL/	ND 2120	1		
Red	State gistrar		31. Date filed (Month, Day, Year)	32. Registr	ars Signa	M. A	ede	•							

DHMH 17 Rev 1/2001

			1 - State Registrar	ate of Maryland	/ Depa		t of H	ealth a		lental Hygi	ene		20600
	Physici	an	Decedent's Name (First, Middle, Last)				9 OI L	Jealli		2. Date of Death Month	Day 12,20		28693 3. Time of Death
	/Medic Examin		WAVERLY 4a. Facility Name (If not institution, give stree		ON,	4b. City,		Location o		August	4c. County		4:45A M
	Funeral Director		Wilson Health C 5. Social Security Number 180-16-4990 Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under Months	aith 1 Year Days	ners If Under Hours	buro 24 Hrs. Min.	8. Date of Birth (Month, Day, Aug. 3,		9. Birthp	MERY lace (State or Foreign hsylvania
	the Maryland 28a-f show	ector	10a. State 10b. County MD MOntgom 10e. Street and Number		Town or Lo	arks		ā		140	Cini(1)		0d. Inside City Limits 1⊠Yes 2 □ No
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic event, the Madical Exercise final by notified at	Completed by Funeral Director	24301 Burnt Hil 11. Marital Status 1 □ Nøver Married 2 (Married	Vas Decedent Ever in U.S. med Forces? EYes 2 No Yes, Give dear or Dates: 42-5	2 16a. Dece	1 ☐ Yes 2	ent of Hi ify Cubar	spanic Orig n, Mexican Specify:		ecify Yes or No- Rican, etc.)	14. Rac	S.A. e - Americ ck, White,	an Indian, etc. ack
	filed within Hygiene. other than and, the Mercant, the Mercant			College (1-4or 5+)		kind of wor DO NOT us Cal		nnol	ogis			.I.H	•
Maryland	should be and Mental I marked o	To Be	Waverly Woodso 19a. Informant's Name/Relationship (Type, F		19h Maili	na Address	(Street 2]	Loui	se Bax	ter		Codo
Baltimore, Ma	permit. Pages 1 and 2 sho Department of Health and Important: If Itam 27 is mu any injury or othar trauma		Joann Woodson (20a. Method of Disposition 1	Wife) val from State	243 ce of Disponence, cree ro F	01 Busition (Nameratory or of ouner) 2. Name and	urni ne of ther place al S	t Hill Brv 8	11 F 8-15 y SN	Rd., Cla	arksbı Oc. Location - Alexaı FUNERA	urg, City or To ndri AL H	MD 20871 www, State a, VA OME, P.A.
THE SHIP	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate manse.	ns that caused the death. use on each line. Due to (or as a conseque)	Do not ent	er the mode		g, such as					Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a conseque	nce of):								
P.O. Box 68	that the death certifica ted by the attending ph detached for use as th	Physician/Med	in the past 12 months?	yes, outcome of pregnand □Live birth 2 □ Fetal d □ Pregnant at time of dea □ Unknown	eath 3[Ectopic pre					23d. Dat Mo	e of delive	r y Day Year
Ś	The law requires that the ste has been signed by the page 2 should be detache	by	Part II. Other significant conditions contribu	iting to death but not result	ing in the u	nderlying ca	ause give	en in Part I.			acco use cont	ribute to th	ably 4 Onknown
al Record	ilclan: The law r certificate has be rector, page 2 sh	Completed								24a. Was an autopsy perform 1 Yes 2	ed?		psy findings available inpletion of cause of 2 No
Division of Vital	tanding Physeath. or; After this the funeral di	Certification: To Be	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could need be	Ba. Date of Injury (Month, Day Year) 3e. Place of Injury - At hom	8b. Time o Injury	f 28	Bc. Injury Work	er: 4 Mu	rsing Ho		nce 6 Oth	ed	/) I Route Number,
Ö	To the Hospital or Attan within 24 hours after deat To tha Funaral Diractor; completely filled in by the		29a. Certifier 1 Certifying Physicia	building, etc. (Specify)	edge, deat	h occurred a	at the tim	ne, date and	d place,	City or Town,	use(s) and ma	nner as st	ated.
	To the He within 24 To tha Fu	Medical	(Check only 2 Medical Examiner: one) 29b. Signature and title Ocertifier	On the basis of examination and manner stated.	n and/or in			number	th occurr	29	d. Date signed	i (Month,	
	01		30. Name and address of person who comple		23а) (Туре,	Print)	٠٠:	201	48		tugust		, 2005
	Sta	ite	Steven Dollns	792. Registrar's Signatu	91	1/20	ssell	Au	e.	Gaith	ersburg	<u>ή</u>	ld.
	Regist	ar	AUG 18 2005	Blown 15.	14900								

			State C	of Maryland / Dep <i>Ce</i>	artment of H		_	giene Reg. No.?	005	28691
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De	Day	Year	3. Time of Death
	/Medic	al	Joe F. Willems					st 14,		02:22A M
	Examin	er	4a. Facility Name (If not institution, give street and no Suburban Hospital	imber)	Bethesda	Location of Death			unty of Death tgomery	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthp	lace (State or Foreign
	Director		156 - 24 - 4542 ¹ ∑M 2□F	84 Yrs.	Months Days	Hours Min.	Nov 2,	1920	The N	etherlands
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				1	0d. Inside City Limits
	Aaryla I sho	ŏ			oution				,	1 ☐ Yes 2 🛣 No
	28a-	rect	Maryland Montgomery 10e. Street and Number	Rockville	10f. Zip Code			10g. Citizer	of What Coun	try?
	h with	Funeral Director	3 Research Court Suite	319	20850			USA		
	ems a	iner	11. Marital Status 12. Was Dec	edent Ever in U.S. 13. orces?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Americ Black, White,	
36	or it	by Fu	If Yes, G	2∭ No ive	1 ☐ Yes 2X No	Specify:			ecify:	
P	flied within 72 hours after death with the Maryland Hygiene. Inter than "natural; or ttems 23a or 28a-f show ant, the Madical Examinat must be notified at	ed b	3 ¥ Widowed 4 □ Divorced Year or I	16a Dece	dent's Usual Occup	ation		16b. Kind	Whit	
215	hin 72	Completed	(Specify only highest grade completed,	1-4or 5+) (Give	kind of work done of DO NOT use retired	during most of work ()	ang			,
21	filed wit Hygiene ther the ent, If e	Com	8		Manager			Unive	ersity	
n D	e d ta	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Su		
Maryland 21215-0036	should be filed within 72 hours after death with the Marylar ind Mental Hygiene. In marked other than "natural; or thems 23a or 28a-f show umatic event, the Medical Exertinal must be notified at	2	(UNK) 19a. Informant's Name/Relationship (Type, Print)	10h Mail	ing Address (Street	(UNK)	on I Florida Alice h	or City or Tr	Frietm	
Na	2 6 5 5		Jodi Willems/daughter		search Ct					
	s 1 and 2 f Health Item 27 I		20a. Method of Disposition	20b. Place of Disp			Date 18,		ion - City or To	
altimore,	Pages nent of int: If It iry or o		1 ☐ Burial 2X Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	State	el Cremato		005		on, Ma	ryland
a	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service Licensee	G_0^2	2. Name and Addres	s of Facility Crematio	n Servi	ce P.	O. Box	784
m —	22 = 29		Beverly & Halth	MO1251 Be	everly L.	Heckrott	e. P.A.	Clark		MD 21029
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not en each line.						Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ongestiv	e Hea	Ut F	ailur	2	- 9	day
	Examiner		Due to	(or as a consequence of):	a Hea	0:			4.	1001
		Jer	Sequentially list conditions, if any, leading to immediate	(ur as a consequence of):	111/1/29	0132	9.2		_	75-6/3
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c							
760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to	(or as a consequence of):						
00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d							
9 XO	eath certific attending p	Physician/Med		atcome of pregnancy				23d	. Date of delive	ry
m	death e atte	iciai	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>				Month	Day Year
о. О	at the de by the a	hys	9 Unknown 9 Unkr	nown						
	res thai igned b	þ	Part II. Other significant conditions contributing to o	death but not resulting in the t	anderlying cause give	en in Part I.				e cause of death?
ord	w require been signal	eted					:	Yes 2 N		· *
Records,	e law has b	Completed					24a. Was		4b. Were autoperior to condeath?	osy findings available npletion of cause of
		e Co	25. Was case referred to medical			00 74 / 75 .	1 Tes	2 2 No	1 ☐ Yes	2 X No
Vita	Attending Physician: r death. ector: After this certific. by the funeral director.	0 0	examiner?	Inpatient 2 ER/Outpatie	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			Other (Specifi	()
Division of	ding Phy h. After thi tuneral	n: T	27. Manner of Death 28a. Date			the state of the s	28d. Describe			
Sio	endin eath. or: Af	catic	2 Accident investigation			Yes 2 □ No				
Š	I or Attence after death Director:	ertification;	determined 286. Place	e of Injury - At home, farm, si ling, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (City or To		umber or Rura	l Route Number,
	Hospital 24 hours a Funeral C	O	29a. Certifier Certifying Physician: To th	e best of my knowledge, dea	th occurred at the tim	e date and place	and due to the	cause(s) an	d manner as st	hete
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examiner: On the	pasis of examination and/or in oner stated.	rvestigation, in my of	pinion, death occur	red at the time,	date and pla	ice, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number		29d. Date s	igned (Month,	Day, Year)
1) ra	MD	DSE	652		Augus	st 16	, 2005
~)cp	1)	30. Name and address of person who completed cau		Print)			<i>_</i>	.1	, 2005 ville MD
\leq	('6'	10	Matthew Potte 31. Date filed (Month Day Year) 32.	mistrar's Signature	7901 N	ledi(a)	Center	· Vr.,	Kock.	ville MO
	° Sta Registr		AUG I 9 2005	histrar's Signature	parle					

O222 AM

50/41/8

Willens, Joe

Certificate of Death

28695

4:25 A^M

3. Time of Death

Birthplace (State or Foreign Country)

10d. fnside City Limits

Approximate Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

1 Yes 2 No

Georgia

Specify: Black

Rag. No.

19

2005

2. Date of Death

Carrie Mae Wright August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gladys Spellman Nursing Center Prince George Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**) F Yrs. Director 261-26-6702 87 Jan 08 1918 Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12598 Ridgely Road 21639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 <u>م</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Colfege (1-4or 5+) 02 homemaker own home .. Pages 1 and 2 should be filed v iment of Health and Mental Hygie tant: If item 27 is marked other t ijury or othar traumatic event, ID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Lovett Mattie Byrd Lovett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12598 Ridgely Road Greensboro, MD 21639 Gwendolyn Wright/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removaf from State permit. Page Depertment of Important: If eny Injury or once. 4 □ Donation 5 □ Other (Specify) Eastern Shore Vet Cm 08/24/05 Hurlock Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 160 Greensboro, MD 21639 Immediate Cause (Final disease or condition chronic renal failure Physician resulting in death) /Medical Due to (or as a consequence of) Examiner arterioschlerotic disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9□ Unknown 9 Unknown The law requires that Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by respiratory failure, malnutrition 1 Yes 2 No 3 Probably 4X Unknown been 24a. Was an certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 XNo Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient ٩ 3 DOA funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c, Injury at Work? Certification: After 1X Naturaf 5 Pending investigation

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D0026024 08/19/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6490 Landover Rd. Su F Landover, MD 20785 32. Registrar's Signature

1 ☐ Yes 2 ☐ No

State Registrar

Medical

2 Accident

3 🗀 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified

Lester Miles, MD 31. Date filed (Month, Day, Year)

6 ☐ Could not be

AUG 2 4 2005

1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

after death Director:

To the Funeral Director to the Funeral Director To the

ů

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

Certificate of Death

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 14, 2005 1:40 P 4c. County of Death Wicomico Birthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry <u>Bookkeeping</u> 20c. Location - City or Town, State Parsonsburg, MD Approximate Interval Between Onset and Death 012 101-23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 → 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date_signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within To tha

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

WILLIAM ROBINS, M.D.,

AUG 1 7 2005

1 - For State Registrar

200 CIVIC AVE., SALISBURY, MD.

29c 1 icense number

				partment of Health and Menta ertificate of Death	Hygiene 2005 28697
	Dhysisi		1. Decedent's Name (First, Middle, Last)	2. Date Mor	e of Death th Day Year
	Physici /Medio		Gye Bok Yi		ust 13, 2005 10:20P M
4	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			2617 Belle Crest Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Silver Spring ay) If Under 1 Year If Under 24 Hrs. 8, Date	Montgomery
	Funeral Director		214-17-8234 1-2M 2 - F 71 Yrs		9. Birthplace (State or Foreign Country) Korea
			Usual Residence of Decedent		
	ırylan show	_	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
	8e-f s	Director	Maryland Montgomery Silver		1 ☐ Yes 2 ☐ No
	th with the		10e. Street and Number 2617 Belle Crest Lane	101. Zip Code 20906	10g. Citizen of What Country? Republic of Korea
9	172 hours after death with the Maryland "natural", or Itams 23a or 28e-f show calcal Exercitive to use be routilised at	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et Yes 2 → No Specify: 	Black, White, etc.
003	hours ural',	d by	3 Widowed 4 Divorced Year or Dates		Specify: Asian
Maryland 21215-0036	within ane. than "	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) Grocerer	Self Employed
102	Hyg tha nt,	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	
/lar	2 should be a and Mental I is marked o reumatic ave	To B	Kyung Ku Yi	Nahmee Parl	k
lar)	es 1 and 2 should b of Health and Ment fitam 27 is marked r other traumatic a			ailing Address (Street and Number or Rural Route	
	and lealth m 27 her tr			7 Belle Crest Ln; Silve	
Baltimore,	mit. Pages partment of hoortant: If its portant: If its its injury or ot		cemetery, c	rematory or other place) Memorial Park 8/17/200	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Myclin Woler	22. Name and Address of Facility Hines-H 11800 New Hampshire Ave	Rinaldi Funeral Home e; Silver Spring MD 20904
	a -d		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter the mode of dying, such as cardiac or respira	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Stomach Cancer a. Due to (or as a consequence of):		5 Years
	Examiner				
	₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		
8760,	cate be ex ohysician the burial	ai E	bue to (or as a consequence of).		
687	phys phys s the	edicai	d		
Box (eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
o.	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year
5, Р	igned be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e	. Did tobacco use contribute to the cause of death?
rd	w require been sig should b				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Records,	e law has b	Completed			. Was an autopsy performed? Yes 2 ⊇No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital		Be C	25. Was case referred to medical	26. Place of Death (Check	
of V	d s	To	examiner? 1 ☐ Yes 2 ☒ No	ient 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)
ion o	Attanding Ph r death. actor: After th by the funeral		27. Manner of Death 1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injure (Month, Day Year)		scribe how injury occurred
Division	al or Atta s after de l Diracto d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Loca City	ation (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de control of examination and/or and manner stated.	eath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
	To tha within 2 To tha I Complet	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	2		1 follows	D45880	8/15/2005
			30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Leon Kwan M.D. 1396 Piccard Dr	e.; Rockville MD 20850	
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 8 2005 Registrar's Signature	set.	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 45087 Month OP Year **Physician** IDEN HRMSTRON G /Medical County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner MEDICAL JUSEPHS lowson KALTIMORE ENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 M 2 □ F N-A Yrs. MARYLAND Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in important: If term 23s or 28s-1 show important: If term 27s marked other than "natural", or thems 23s or 28s-1 show any Injury or other traumatic event, it is Medical Examinat must be notified at BALTIMORE YARKU, 1/E 1 ☐ Yes 2 ☐ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surhame) Be MIZNOY HRMSTICON G ELLER 2 1000 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLAX LEAF MOTHER STEDHANIE ZEIIER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Valley Mem. Gardens 9-2-05 4 ☐ Donation 5 ☐ Other (Specify) Limonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL CHADEL EVANS 8800 HARFORD RD MARKVILLE MO 21234 lations that caused the fleath. Do not enter the mode of dying, such as cardiac of respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or comp. shock, or heart failure List only of Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) rivical Examiner Examiner certificate be executed attending physician and I for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? to Vie STANO 1'_'Yee 2'_No or Attending Physician: efter death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Man or of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 Yes 2 □ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified n44809 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1250ph med. Ctr., Towson MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 02 2005 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10 Mm ARMSTRONG 2 0.5 /Medical 4c. County of Death
BALTIMORE 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street and number) Examiner MEDICAL JUSEPHS ENTER lowson If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day) If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 F Months MARYLAND N-A 0 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mentel Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Medical Example must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location BALTIMORE 1 ☐ Yes 2 ☐ No HARKVILLE mo Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21234 USA VCLIFFE 2620 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 If Yes, Give 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify altimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MINDY 1000 ARMSTRON G LELLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FLAXIEAE GRAND MOTTIES STEPHANIE ZEILER 20b. Place of Disposition (Name of cemetery, crematory or other place)

DUIANEY MEMORIAL CARDENS 200 T 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Imonium MD 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL CHAPEL 22. Nama and Address of Facility EVANS 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 21254 HARKVILLE, MO Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine physician and s the buriel-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or as a consequence of) attending p 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I certificete has been signed by the irector, page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 L Yes 3 1216 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) erei Director: After this filled in by the funeral di 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of edical Certification: 1 Matural 5 Pending investigation 1 Tyes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funerei C completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 44809 -00 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) med clr. 125012 M M St 31. Date tiled (Month, Day, Year) SEP 0 2 32. Registrar's Signature State 2005 Registrar Conde

DHMH 16 Rev 6/95

		1	State of Maryland / Department of Health and N State Of Maryland / Department of Health and N Certificate of Death		gien 2 UU5	28700
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physicia		Dorothy Marie Ault	Month	Day Year	2:25 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Dea	
			Sacred Meart Hospital Cumber Land	8. Date of Birt	AlleGA	
	Funeral		5. Social Security Number 6. Sex 1 Mark 2 XF 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min.	June 2	9. 1927 Wes	rthplabe (State or Foreign Country) St Virginia
	Director	-	Usual Residence of Decedent	June 2),1)2/ NC.	
	yiano how	. [10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
	Ba-fs	cto	WV Mineral Keyser		10g. Citizen of What C	
	with th	Dire	10e. Street and Number Rt. 3, Box 6087		US.	
	eath v	eral	346 Carroll Avenue 26726 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No		erican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menter Hygene. I Health and Menter Hygene. I Health and Menter Hygene. I have seen than "naturel," or Items 23s or 28s-f show tiem 27 is marked other than "naturel", or Item 85s-f show other treumstic event, I have digal Examinations to callify a later treumstic event, I have digal Examinations.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes or Dates: Armed Forces? 1 Yes, specify Cuban, Mexican, Puerforces 1 Yes, Give 1 Yes, Give 1 Yes 2 No Specify:	o Hican, etc.)	Black, Wh	White
21215-0036	2 hou	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	rking	16b. Kind of Busines	s/Industry
21	ithin 7 19.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		O II	
N	filed with Hygiene. other thei		8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name		Own Home , Maiden Sumame)	
anc	ould be fi Mental H arked of atic ever	Be c	The first of the f		rine Derem	er -
Maryland	should nd Men s marke umatic	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rt			
	and 2 sealth ar m 27 is		Tina M. Ault Hyken/Granddaughter 1295 Polo Lake Ell	lisville		
Baltimore,	bages 1 and on the of Healint: If item 2 y or other		20a. Method of Disposition 1 \(\mathbb{N} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) Removal from State 1 \(\mathbb{N} \) Donation 5 \(\mathbb{O}\) Other (Specify) Potomac Memorial Gardens	Aug 31 2005	20c. Location - City of	
Baltin	permit. Pages Department of I Importent: If ite eny injury or of		21. Signature of Experal Service Licenses 22. Name and Address of Facility 85 S. Main Street	Smith	Funeral Ho	
			23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			Approximate Interval Between
	Pnysician :		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Selection description			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
Ė	Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			
	ed sit	ulne	cause. Enter Underlying Cause (Disease or injury			Ē.
	cate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of)			
68760,	e be e /siciar e buri		d			
_		Aedical	UE FEMALE.			
Box	The law requires that the death certificate has been signed by the attending pipage 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 Yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of d Month	delivery Day Year
P.0	es that the de igned by the a be detached t	Phys	9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did	tobacco use contribute	to the cause of death?
Ś,	requires th been signed should be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in reactions.		1 -	Probably 4 Unknown
Record	e law re has bee je 2 sho	Completed		24a. Was	opsy prior t	autopsy findings available o completion of cause of
H.	The ate h	Con		1 Yes	formed? death 2000 1 □ Y	es 2 No
Vital	Physician: The this certificate ral director, pag	Be	examiner? / Hospital: Co Other:	ath (Check only		
of	phys this aldi	- T	27 Manner of Peath 28a. Tate of Injury 28b. Time of 28c. Injury at		sidence 6 Other (S how injury occurred	pecity)
	iding f th. : After s funer	itlon	1 KN tural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Division	or Attending after death. Director: Afte In by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or own, State)	Rural Route Number,
	Hospite 4 hours Funerel ely fillec	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the curred at the time	e cause(s) and manner a, date and place, and c	as stated. lue to the cause(s)
	To the To the Complet	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Dey, Year)
	F > F 0		82 Sus Physician D43178		8/27/5	
	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	/		1 10 N
J	7		30. Name and address of person who completed cause of death (Item/23a) (Type, Print) (Bruce C. Ve. O., ve. m) MPH Secre RHCe of Hospifel 31. Date filed (Month, Day, Year) 32. Registrar's Signature	700 Sit	1-1) - (0-	-40-6, Me
	St Regist	ate rar	31. Date filed (Month, Day, 19ar)			

DHMH 17 Rev 1/2001

		•	1 = State Amend Item	ns 25,26,27	aryland / Departur 30 per Ur	artment of C847 0	1702/05dh Death			05 2870
	Physici		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month		3. Time of Death
	/Medic	al	Catherine R.			1		August		
	Examin	er	4a. Fecility Name (If not institution, g				r Location of Death		4c. County of	
			212 B King Ge 5. Social Security Number 6.		E e (In yrs. last birthday)	Annapol		8. Date of Birtl	9	Arundel Birthplece (State or Foreign Country)
	Funeral Director		210-30-5430 Usual Residence of Decedent	1□M 2√F	64 Yrs.	Months Days	Hours Min.	(Month, Da) NOV 6,	1940]	Pennsylvania
	and and	-	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary	tor	MD Anne Ar	unde1	Ar	napolis				1 Tes 2 No
	r 28e	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th wit	Funeral Director	212 B King Geo	rge Street			21401		US	Α
	eme.	ner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f ahow he Mudical Examiner must be notitled at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	1 ☐ Yes 21 No	Specify:		Specify:	white
ည	72 ho	Completed	15. Decedent's (Specify only highest)		(Give	dent's Usual Occup kind of work done	during most of work	unk ing	16b. Kind of Busin	ness/Industry
7	han han	du	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	DO NOT use retire	d)		resea	rch
7	iled w tygie her t nt, th	ပိ	12 17. Father's Name (First, Middle, La	5 +			18. Mother's Name	e (First, Middle,	Maiden Sumame)	LCII
and	od be f) Be	John Elwood Pa						Espensh	ade
Maryland	should Me mark	ဂ္	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Numbe	r, City or Town, Sta	ate, Zip Code)
Ž	nd 2.		Rachel Perella/	daughter	2305	Oxford Si	hire Court	Waldor	f, MD 2	0603
altimore,	ages 1 and 2 nt of Health an : If Item 27 is or other trace		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla		Date	20c. Location - Ci	ty or Town, State
Baltin	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f ahow any injury or other traumatic event, the Mydical Examination or notified at ance.		21. Signal one of Fun ral Servine Lice ROULTH S	40.0	ertor S	2. Name and Addre tate Anat altimore,	omy Board		Baltimor	e Street
		6	23a, Part 1. Enter the disease, or co	emplications that cause	d the death. Do not en				rest,	Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Me	tastatic a consequence of):	Enda	metrial	Cane	ш	Onset and Death
*	pe is	lner	Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	à consequence oi):					
68760,	icate be executed physician and s the burial-transit	al Examiner	that intiated events resulting in death) Last	c. Due to (or as	a consequence of):					
Ψ	On rd	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			_	17.15to	23d. Date (of delivery
.O. Box	O O D	Physician/M	in the past 12 months? 1 □ Yes 2)⊠nNo 9 □ Unknown			□Ectopic pregnand □ Other (specify) _	:y		Month	n Day Year
α.	ires that the signed by th d be detache	by	Part II. Other significant condition	s contributing to death 1	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	1-	ute to the cause of death?
Records,	neeu	Completed						24a. Was		re autopsy findings available
Rec	e lav	du						autop perfo	rmed? pric	or to completion of cause of ath?
e		မ Co	25. Was case referred to medical				26. Place of Deat			Yes 2 No
Vital	Physician: this certific ral director,	o Be	examiner?	Hospital:	ent ZETV Outpatie	ent 3 DOA Ot	han		dence 6 Other	(Specify)
on of	ling After fune	Ilon: T	27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b. Time	of 28c. Inju			now injury occurred	
Division	200>	ertification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At home, farm, s tc. (Specify)			28f. Location (S City or Tox		or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory (illed in b	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis of and manner s	of examination and/or i	ath occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To th within To th	Me	29b. Signature and title of contier	#		29c. Licen D332	se number		29d. Date signed (
•			30. Name and addres of person w	no completed cause of	death (Itam 22a) /Time		1113,3			7.
	10		Frederick				in Avenue	Chevy C	hase MD	20815
	St	ate	31. Date filed (Month, Day, Year)		rar's Signature	11TOCOID)	وعالمات بد	JIL Y J	اللك و الساء	<u> </u>
	Regist		SEP 0 2 2005		As Anach	1				
DH	MH 17 Rev 1/2	2001	OE! (1 & 200)		100					

de, 26, 24c, 3c

			State of Mar				ontal Hygi	ene		20702
			State Registrar	Cer	rtificate of De	eath		g. No. 20 (10	28702
	Physicia	an a	1. Decedent's Name (First, Middle, Last) EDITH J. ANDERSON				2. Date of Death Month	Day Y	'ear	3. Time of Death
	/Medic	al			4b. City, Town, or Lo	ncation of Death	AUGUST	23 26 4c. County of	Doath	7:15 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) Holy Cross Nursing & Rehab		Burtonsvi			Howard	Dodui	
	Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/13/19		Birthpla	ce (State or Foreign
	Director			89 Yrs.	Widitiis Days	TIOUTS INTI.	07/13/19	916		gia
	and w		Usual Residence of Decedent 10a. State 10b. County 1	IOc. City, Town or Lo	cation				100	d. Inside City Limits
	Maryl -f sho	ţ	MD Howard	Columbia						1 □Yes 🏧No
	h the	lrec	10e. Street and Number	<u> </u>	10f. Zip Code		10	g. Citizen of Wh	at Countr	y?
	23a (23a (23a (23a (23a (23a (23a (23a (Funeral Director	6505 Allview Drive		21046			JSA		
	ltams	nue	11. Marital Status 1 □ Never Married 12. Was Decedent Ev. Armed Forces? 1 □ Yes 2 2 1 □ Yes 2 2 1 □ Yes	er in U.S. 13. \	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Black,	White, et	
2	filed within 72 hours after death with the Maryland Hyglene. that than "natural; or Itams 23s or 28s-f show ant, the Modical Evairs or must be notified a	þ	1 ☐ Never Married		1 ☐ Yes 2XXNo	Specify:		Specify:	Whit	е
0000-C17	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ring most of worki	ng 1	6b. Kind of Busi	ness/Indu	stry
7	ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+))	DO NOT use retired) emaker	J		Own Home	,	
N	filed v Hygle thar ti		12 17. Father's Name (First, Middle, Last)	Home		8. Mother's Name	(First, Middle, M			
yland	ld be ental ked o	To Be	Isacc Luther Eubanks			Blanche	M. Cros	by		
_	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Menth Hyglens. If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Modical Evant art must be notified at	_	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				ate, Zip C	Code)
_	1 and 2 Health a am 27 l		Phillip Anderson (husband)		Allview Dr		ımbia, M			
<u>o</u>	permit. Pages 1 and Department of Heall Important: If Itam 2 any Injury or other 900g.		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State		nsition (Name of matory or other place)		5/2005 B	0c. Location - Ci	•	
saitimore,	it. Partmen rtant: njury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		ce Cremator 2. Name and Address					
g	permi Depa Impo any to		21. Signature of Parishal Service Licenses		5555 Twin M					
	10 5 6		23a. Part1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ent	ter the mode of dying,	such as cardiac o	or respiratory arre	st,	-	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	ROSEPS	-				(3WKS
	/Medical Examiner		resulting in death)	consequence of):						
	Examine	<u>_</u>	Sequentially list conditions, b. Due to (or as a life sequentially list conditions).	consequence of):					_	
	insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Irju.) that initiated events c.	30,000						
<u>,</u>	ie be executed /sician and e burial-transi		resulting in death) Last C. Due to (or as a c	consequence of):					1	
3760	eath certificate be executed attending physician and for use as the burial-transit	Ical	d							
X Q	The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of	nrognana.		-		201.0		•
XOR	attend for us	cian	in the past 12 months?	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date Monti		/ Day Year
o.	the dr	hysic	1 Yes 2 No 9 Unknown 9 Unknown							
رس ح	res that the designed by the a		Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given	in Part I.	23e. Did tob	acco use contrib		-
Vital Records,	w require been sig should b	Completed by	Ilaus. Demonli	a:			1 ☐ Ye	s 2□No 3	Probal	oly 4 Denknown
ပ္ပ	law r nas be	nple					24a. Was ar autopsy perform	/ / pri	ere autops or to comp ath?	sy findings available pletion of cause of
E E							1 ☐ Yes 2	☑ No 1 L	Yes 2	□ No
<u> </u>	siclan: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ M6 Hospital: 1 □ Inpatient	t 2 ☐ ER/Outpatier	Othor		n <i>(Check only one</i> me 5 ☐ Reside		(Specify)	+
Ö	g Phys er this eral dii	1	27. Manner of Death 28a. Date of Injury	28b Time o	The Court Co	at	28d. Describe ho			
Division of	ath. or: After ne funer	Certification:	2 Accident investigation	r ear, injury		es 2 No				
N≥	I or Attand after death Diractor: /	rtiflo	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Str City or Town		or Rural	Route Number,
<u>Ω</u>	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of	my knowledge deat	th occurred at the time	date and place	and due to the ca	use(s) and man	nor as sta	ted
	To the Hospital within 24 hours a To the Funeral is completely filled	Medical	(Check only one) Continue Co	examination and/or in						
	To the Within To the	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Month, D	ay, Year)
	1		>Xrubodust	Ocen. H	000	57630	2 1	Aug 2	3,	2005
	N		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print) Holy Cr	coss Nurs	sing & Ro	ehab Cen	ter	
			Anuradha Arun, MD 3415	Greencas	stle Rd. I	Burtonsv	ille, MD	20866		
	Sta Regist		SEP 0 2 2005	en Di	Agente					

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/Medi	an cal	Thelma		Brunner			July	7 Day 2	005 ^{Year}	3:10
Examir		4a. Facility Name (If not institution, given	ve street and number	-)	4b. City, To	wn, or Locat	ion of Death	4c. Cou	inty of Death	
		Millennium - So				ewater			ne Aru	
uneral rector		579-01-6546	Sex 7. A 1 □ M 2√2√F	ge (In yrs. last birtho	Months [Days Hou		Day, Year)	Coun	ace (State or try) Land
Mou		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				11	Od. Inside City
a-fa-	ctor	MD Anne Ar	undel	Edge	water					1 Tes
or 28	Director	10e. Street and Number			10f. Zip C			10g. Citizen	of What Coun	try?
9 238	Frai	144 Washington	Street 12. Was Deceden	t Ever in II S	13 Was Doordon	2103		No. 14 I	USA Race - Americ	an Indian
r than "natural", or iteme 23a or 28a-f show the Modical Examiner must be notified at	Funeral	11, Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces 1 Yes 2 If Yes, Give	? {No	If Yes, specify		c Origin? (Specify Yes or kican, Puerto Rican, etc.)		Black, White,	
ural.	d by	3 X Widowed 4 □ Divorced	Year or Dates	:						
n "nat	Completed	(Specify only highest gr			ecedent's Usual (Give kind of work fe. DO NOT use	done during	most of working	16b. Kind c	f Business/Inc	lustry
	mo	Elementary/Secondary (0-12)	College (1-40)	,	type Ope	erator		Ne	ewspape	r
event, I	Be	17. Father's Name (First, Middle, Last Edwin Nutwell D					lother's Name <i>(First, Mid</i> argaret Lea			
item 27 le markad o other traumatic eve	2	19a. Informant's Name/Relationship		19b. N	lailing Address (S		imber or Rural Route Nu			Code)
Item 27 le other trau		Glenda Neblett					y, Berthoud	-		
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [20b. Place of D cemetery,	isposition (Name crematory or oth	of er place)	Date	20c. Locati	on - City or To	wn, State
rtant: I		' 4 □ Donation 5 □ Other (Special	ify)	Quaker			7-12-2005	Gales	sville,	MD
Important: If any injury or once.		21. Signature of Funeral Service Lice				sty Fu	ineral Home, Avenue, Ann		MD 214	i01
		23a. Part Enter the dease, or conshock, or heart failure. List only	pications that cause one cause on each	ed the death. Do not line.						Approximate Interval Between
sician		Immediate Cause (Final disease or condition	a Cae	cliece F		nia			and the same of th	Onset and De
edical miner		resulting in death)	Due to (or a	s a consequence of)	/		11	1		
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Dee to (or a	s a consequence of)	1/0		A CAL STATE	EK	-	
ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.			1	OBY WEDIO			<u> </u>
physician and the burial-transit		resulting in death) Last	Due to (or a	s a consequence of)		IENC JOH WE	NO DEVINEDICAL PRIM			
g phys as the	edic		d		1,000	V				
attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yo		e of pregnancy 2 Petal death at time of death	3 Ectopic preg			23d.	Date of delive Month	r y Day Ye
be be		9 ☐ Unknown / Part II. Other significant conditions		but not resulting in the	ne undertving cau	se aiven in F	Part I. 23e. D	id tobacco use o	contribute to th	e cause of de
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gned be de	2						24a. V	Vas an 24	b. Were autor	osy findings av
been signed should be de	ple						p 1 □ Ye	erformed?	death?	
has been signed je 2 should be de	Comple							ilv one)		
certificate has been signed rector, page 2 should be de	Be Completed	25. Was case referred to medical examiner?	Hospital:		-	Other	Place of Death (Check or			
this certificate has been signed al director, page 2 should be de	To Be		Hospital: 1 ☐ Inpa 28a. Date of In		198.0	Other: 4	ursing Home 5 🗆 🖹)
this certificate has been signed al director, page 2 should be de	To Be	examiner? 1 Xes 2 27. Manner of Death	28a. Date of In	jury 28b. Tin Day Year) Inju	198.0	Other	ursing Home 5 A Page 28d. Descri	tesidence 6 🗆	curred)
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State of Maryland / Department of Health and Mental Hygiene 2005 28704 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 406-UST Year **Physician** Thomas Harvey Bell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nymber) Examiner ALTIMERE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1**∑**M 2□F 64 January 16, 1941 Maryland Director 214-38-6458 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other treumatic event. If a Medical Examiner must be notified at 1 √Yes 2 No Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o Items 23a 21234 U.S.A. 3023 Lavender Avenue Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: 3 Widowed 4 Divorced White "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automotive Business Self Employed 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maude Green William Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3023 Lavender Avenue Baltimore, Maryland 21234 Olga A. Bell - Wife item 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition o i Gardens of Faith Cemetery 9/03/2005 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) ō Department of the state of the Baltimore 21. Signature of Maral Segvice Personantes F. Miner 22. Name and Address of FacilityLeonard J. Ruck, Inc. reuls 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNKNOWN Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, CANCER LUNG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WO018 230 AUGUST 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULDVARD KALATHIL SHASHIDHARAN, MD BALTIMORE, MD 21239 egistrar's Signatur 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

	11		For State Registrar	State of Mai	yland / De	ertificate of	neaith and i Death		g. No.	28705
ı	Physici	an	Decedent's Name (First, Middle, La John	Michael	Blak	Δ		2. Date of Death Month August		3. Time of Death 6:30pmM
	/Medic Examin		4a. Facility Name (If not institution, given		Diak		r Location of Death		4c. County of Dea	
			2826 Canada Hi	11 Road		Mye	rsville		Freder	ick
	Funeral Director		5. Social Security Number 220-40-1502 Usual Residence of Decedent	Sex 7. Age	(In yrs. last birthda 63 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Spe 4,	^{Year)} 9. Bir L941 Ma	thplace (State or Foreign ountry) ryland
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural" or items 24 or 28a-f show he diest Examiner must be multiled at	tor	10a. State 10b. County Maryland Freder		10c. City, Town or Myers	Location SVille				10d. Inside City Limits 1 ☐ Yes 2 ☑No
	with the	Funeral Director	10e. Street and Number 2826 Canada Hill	. Road	***	10f. Zip Code	21773	10	Og. Citizen of What Co	•
	death ms 2;	nera	11. Marital Slatus	12. Was Decedent Ev	er in U.S. 1	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.	l by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 21② No	Specify:	o Hican, etc.)	Black, Whi	_{te, etc.} √hite
5	"natu	letec	15. Decedent's E (Specify only highest gr		16a. De	cedent's Usual Occup ive kind of work done b. DO NOT use retired	ation during most of wor	king 1	6b. Kind of Business	/Industry
12	iene. iene. rthan	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ryland Sta			Law Enfor	cement
g	al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Last)				ne (First, Middle, M		
<u>Ş</u> a	ould b Ments sarked	ပ	John	Bernard	Bla		Cather		eresa	Blake
Maryland	d 2 sh th and 7 is rr traum		Julie D. Blake -			ailing Address (Street				
	f Heali f Heali fem 2		20a. Method of Disposition	wire	20b. Place of Dis	O Canada H sposition (Name of rematory or other place	III Koad	Myersvi Date 2	LLe Mary Oc. Location - City or	Land 21773 Town, State
<u>E</u>	Page: nent o ant: If ary or		1 ☐ Burial 2 🖾 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci.			urg Cremat	1	26 2005	Smithelin	ea Mil
Baltimore,	permit. Departr Imports any inji		21. Signature of Funeral Service Lice	0	- 1	22. Name and Addre Keene 106 East (ss of Facility			19.19
	777		23a. Part1. Enter the disease, or com shock, or heart failure. List only		ne death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
į	Physician		Immediate Cause (Final disease or condition resulting in death)	a. <u>Metast</u>	atic Par	creatic Ca	ncer			Onset and Death 9 months
	/Medical Examiner			Due to (or as a	consequence of):					
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of).					
	tificate be executed g physician and as the burial-transit	Aedical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	be ex sician burial	al E		. Due to (or as a c	consequence of):					
687	ificate g phys as the	edic		_ d						******
P.O. Box	death cer e attendir id for use	by Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death	B Ectopic pregnancy Control of the c			23d. Date of del Month	ivery Day Year
S, P.	s that t ned by detail	y Ph	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute Id	the cause of death?
rds	w requires to been signer should be							1 ☐ Yes	2 □ No 3 X Pr	obabiy 4 🗆 Unknown
Division of Vital Record	e la has	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Managert.				th Check on one		
of	Physi r this c ral dire	2	1 Yes 2 XNo 27. Manner of Death		2 ER/Outpat			ome 5 X Residen 28d. Describe hov	ice 6 Other (Spec	cify)
ion	Attending Ph er death. rector: After th by the funeral	atlon:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day)	(ear) Injur	/ Worl	k? Yes 2 □ No	20d. Describe nov	Inquiry occurred	
Divis	al or Attends after death	Certificat	3 Suicide 6 Could not b determined		- Al home, farm, (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 X Certifying Ph	ysicien: To the best of one of the basis of example and manner state	xamination and/or	ath occurred at the timinvestigation, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
		M	29b. Signature and title of certifier	Vala.	MT	29c. License		290	d. Date signed (Monti	n, Day, Year)
)	7		•	BUN	اللا		184	A	ugust 25,	2005
c	2U'		30. Name a address of person who Elhamy Eskander,				t. Frede	rick. Mar	vland 2170)1
	Sta	-	31. Date filed (Month, Day, Year) SEP 0 2 200	2. Registrar's	Signature		,		J 411	
	Registr	al I	3EF U & 200	S. M. O. BAR	De John	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year **Physician** 5:20a Clarence E. Boston 2005 /Medical Sept 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8043 Lansdale Road Baltimore
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. 8. Date of Birth (Month, Day, Year) May 20, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**№** M 2□F MAryland 216-28-6318 72 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: if Itam 27 is marked other than "natural", or Itams 23s or 28s-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic event, the Medical Examinar must be redified at MD Baltimore Baltimore 1 ☐ Yes 2 X No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8043 Lansdale Road 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry C.J.Landfelder Elementary/Secondary (0-12) College (1-4or 5+) HeavyEquipmentOperator Construction 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Boston MAy Fortman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane Boston /wife 8043 Lansdale Road Baltimore M D 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCemetery 9/6/05 permit. Page Department of Important: If any injury or once. Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder **Physician** Zyern /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) the be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown COPD 1 ☐ Yes 2 ☐ No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 2 A No certificate 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Z Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and trie of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weenberg Concer First, the at Frenklin. So Concer First, the at Frenklin. So Bolt and 211370

014356

2005

			1 - For Stete Registrar	State of M	1aryland		artment of H tificate of			R	eg. No. 20	05	28707
Н	Physici	an	1. Decedent's Name (First, Middle, Last) Rita Burch							2. Date of Dear Month Aug 31	Day	Year	3. Time of Death 9:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number	r)		4b. City, Town, o	or Location o	of Death	Aug Ji	4c. County	of Death	9.40 A.
			2413 Old Mystic				Crof					Arun	
	Funeral Director		5. Social Security Number 6. Sex 577 16 5985 1□	M 25 7. A	nge (In yrs. Ia 86	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth Month, Pay Dec 25	Ye <i>ar)</i> 1918	9. Birthp Coun Wash	lace (State or Foreign htry)
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation						0d. Inside City Limits
	Maryla	to	Maryland Anne Aru	ındel		rofton						- 1	1 ☐ Yes 2 ☐ No
	or 28e	Funeral Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of		•
	ns 23e	eral	2413 Old Mystic (2. Was Deceden	nt Ever in U.S	S. 13. V	2111		gin? (Spec	cify Yes or No-	United 14. Rac	Stat e - Americ	
စ္အ	or Iten	/ Fun	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give	?	· ·	Vas Decedent of I IYes, specify Cub I□Yes 2♀\o	an, Mexican Specify:	, Puerto R	lican, etc.)		ck, White,	etc.
8	turel',	ed by	3 ☐XWidowed 4 ☐ Divorced	Year or Dates	:		MXX lent's Usual Occur				16b. Kind of B	N	ite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Medical Exercities main be notified at	Completed	(Specify only highest grade Elementary/Secondary (0-12)		r 5+)	(Give life. I	kind of work done OO NOT use retire	during most	of workin	g			32011)
121	filed wi Hygien ther th nt, the		6th 17. Father's Name (First, Middle, Last)			House	ewife	18. Mothe	r's Name	(First, Middle, I	Own H		
lano	Aental i	To Be	George John	Gateau						ertson		,	
altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: it item 27 is marked other than "naturel; or items 23e or 28e-1 show apprintury or other treumetic event, the Medical Examination and Dance.		19a Informant's Name/Relationship (Type JoAnn Parsons (Dat				og Address <i>(Street</i> Old Myst						Code)
ore,	ges 1 at of He tf item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	emoval from Stat	e ce	metery, cren	sition (Name of natory or other pla			te, 2005			
il in	artmen artmen ortent: injury		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service/Ligense	90 4	Mar	-	Veterans Name and Addre						Maryland
ä	Departing Department of the policy in the po		Janis J. Aran	7-mou	0257	A	exandria	Ferr	y Rd,	Clinto	on, MD	20735	033 010
			23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	e cause on each	line.	. Do not ent			cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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8760,	ficate be executed physician and is the burial-transit		resulting in death) Last		is a consequ	ence of):							
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Box	death certificate le attending phys ad for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Fetel	death 3□	Ectopic pregnanc Other (specify)	у				te of delive nth	ory Day Year
P.0	that the died by the detached	Phys	9 ☐ Unknown Part II. Other significant conditions con	9□ Unknown	but not recul	ting in the u	adorhina agusa ar	von in Bart I		23a Did tol	nacon use cont	ribute to th	e cause of death?
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Records,	aw as b 2 si	Completed								24a. Was a	V 41 1	prior to con	psy findings available impletion of cause of
al B	Th ate pag	e Con	OF Was soon referred to medical								No	death?	2 No
f Vital	Physician: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 □ Inpa	tient 2 🗆 E	ER/Outpatien	t 3 DOA Ott	205	of Death	(Check only on	ence 6 ⊡Oth	er (Specify	······································
n of			27. Manner of D₁at 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury	28c. Inju Wo	rk?		8d. Vescribe ho	ow injury occur	red	
Division	ten leat tor: the	ertification;	2 ccident investigation 3 Suicide 6 Could not be determined	28e. Place of I	njury - At hor	ne, farm, str	M 1 =	Yes 2 N	-			er or Rura	l Route Number,
Ö	Hospitel or A tours after Funerel Directely filled in by	0	4 Homicide		etc. (Specify)				<u>l</u>	City or Towr			
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	ician: To the bes ner: On the basis and manner:	of examinati	vledge, death ion and/or in	occurred at the ti vestigation, in my	me, date and opinion, deat	d place, ar th occurre	nd due to the ca	ause(s) and ma ate and place,	inner as st and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		1.0		29c. Licens			2	9d. Date signe	d (Month, l	Day, Year)
,	13		30 Name and address of person who co	mpleted cause of	death (Item	23a) (Type.	Print)	683	<u> </u>	10	149 05	1 3	1,2005
	1		Jeanne Wer	ner, 9	00 P	resta	KK RU	ad t	1300	, Ans	ago/1	s, mi	21401
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 2 2005	32. Regis	strar's Signati	ure some	200						

				1 - For State Registrar	State of Ma	ryland /		rtment of F tificate of		Mental Hy	/giene	41115	28708	
				1. Decedent's Name (First, Middle, Las	0 -					2. Date of D			3. Time of Death	_
		Physici /Medio		CHANDRA	, BEH	ARR	Y			Aug		24, 200	77.79	
		Examin		4a. Facility Name (If not institution, give	_	(•	0 4	r Location of Death	J	4c.	County of De	ath	
				5: Nai Hospita 5. Social Security Number 6. So	0 0	(In yrs. last I		If Under 1 Year	MOY &	R Date of Bi	irth	0.8	irthologo (Ctate or Foreign	
		Funeral Director			M 2₩F	46	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Oct 20			irthplace (State or Foreign Country) cinidad	,
		P		Usual Residence of Decedent						10CL 20	<u>ي لا ي</u>	70 1.1		
		show	_	10a. State 10b. County		10c. City, To							10d. Inside City Limits	
		Be-1	ecto	MD		Ba	ltim				40 000		1 Yes 2 No	
-	,	a or 2	i i	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What C		
4		death with the Maryland ms 23a or 28e-f show rraust be notified at	erai	4601 Pall Mall Ro	12. Was Decedent E	ver in U.S.	13. V	212 /as Decedent of H	lispanic Origin? (Sp	pecify Yes or N	0-	Trini 14. Race - Am	nerican Indian,	_
Scharry	36	within 72 hours after cene. ene. then "natural", or Iter its Madical Exertifier	by Funeral Director	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	lf	Yes, specify Cuba □ Yes 2X No	Specify:	Rican, etc.)		Black, Wh	ite, etc. indian	
0	215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "natural; eumatic event, the Medical Ext	ted	15. Decedent's Ed	lucation	16	a. Deced	ent's Usual Occup	ation		16b. Ki	nd of Busines	s/Industry un	n k
0	215	thin 7.	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5-	-)	life. D	on d of work done in the contract of the contr	during most of world)	ang				
	21	filed wil Hygien other th	Con	12	0		sa		esentativ					_
3	nd	tal High off	Be	17. Father's Name (First, Middle, Last)				unk	18. Mother's Nam	e (First, Middle	e, Maiden	Sumame)	unk	,
3	Z	should be ind Mental marked o umatic eve	²	19a. Informant's Name/Relationship (7	Tuno Brieft	11	ob Mailia	Address (Street	and Number or Rui	m / Courto Mumi	har City a	s Town State	Zin Co do	_
handre	Maryland	d 2 sl th and t7 le r treur		Rosanne Ramroop/n					treet Sou					
Z. U		iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then "naturat", or items 23s or 28e-f show or other treumatic event, Ira Marilcal Examiner cast be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme		ition (Name of atory or other plac		Date		cation - City o		
	Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		`4 □Donation 5 ☑Other (Specify 21. 3 natur Funeral Service Feneral Service Fe		1	S ²²	Name and Addre	ss of Facility Omy Board	655 W	. Bal	timore	Street	
		7 □		23a. Part1 Enter the disease, of comp	////	the death O	Ва	ltimore,	MD 2120	1			Approximate	_
				shock, or heart failure. List only	one cause on each line	ine deain. D 9. <u></u> →	- not ente	0			arrest,		Interval Between Onset and Death	
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	Box	d for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 ☐ Fetal dea		Ectopic pregnancy Other (specify)	/		2	23d. Date of de Month	elivery Day Year	
	P.O.	t the by the archer	hys	9 Unknown	9□ Unknown					_				-
		ss tha gned se del	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the un	derlying cause giv	en in Part I.				to the cause of death?	
	ord	equire en si ould b	ted							1 🗆	Yes 2	□No 3□F	Probably 4 Unknown	
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	al H	: The cate I								1 Yes	ormed? 2 No	1 Ye	s at No	
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	of	Phys r this ral di	To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury (Month, Day		Outpatient Time of	3□ DOA 28c. Injur	4 CHANGE LI	ome 5∐ Res 28d. Describe			ecify)	-
	on	ding th. : Afte s fune	tion	1 Natural 5 Pending 2 Accident investigation		Year)	Injury		k? Yes 2∐No					
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		To the Hospital or Attending Physician: The law requires that the death certificath within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examination:	ge, death and/or inv	occurred at the tirestigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time	cause(s) date and	and manner a I place, and du	as stated. ue to the cause(s)	
		To the within To the comp	M	29b. Signature and title of certifier	19.	MI)	29c. Licens	number		29d. Dat.	e signed (Mor	nth, Day, Year)	
				30. Name and address of person who	completed cause of de	ath (Item 23a	(Type, F	St. B	Baltin	ne	MI) 2/2	01	
		Sta	ate	31. Date filed (Month, Day, Year)	32/Registra			1 100						-
		Regist	rar	SEP 0 2 20	US All Reser	1 15.	GOL	MIL!						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28709 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, Sow **Physician** Ruth Marie Bartolomeo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3A-67 BAINI 46NES HOSPITAL If Under 24 Hrs. | 8 N/A Date of Birth (Month, Day, Year) une 14, 1924 If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2 🗓 F 81 Yrs June Director 212 20 2942 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28s-f show the Medical Exeminar must be notified at Maryland 1 X Yes 2 No N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Annabel Avenue U.S. 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Factory Worker Candy Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event pose. Cora Ruth Fitzhugh Conrad Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Bartolomeo / Husband 610 Annabel Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 9/1/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Danneson 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** MYOCNOLIA inknown /Medical atherosclero Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď 3 Probably 4 GUnknown 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan cate hes l page 2 s 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this: After this funeral c 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 2 2005

30. Name and addrass of person ocompleted cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

on 1 Talck

St-Agnes Hospital 900 Caton Avenue Bultimore, Maryland 32. Registrar's Signature

D47353

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 🔨

801 Brown		For	/pe or Print in Bl State of Maryland	l / Depa	rtment of He	ealth and M	I Copies Iental Hyg	Are Legible	15 28710
	_	Registrar		Cer	tificate of D	eath	2. Date of Dea	ag. No.	
Physicia		Decedent's Name (First, Middle, Last) Rober	t Gerald Brown	n III				28°, 2005°	ar 4:20 P M
/Medic Examin		4a. Facility Name (If not institution, give st. 1213 East Patapsco			4b. City, Town, or to Brookly			4c. County of D	
Funeral Director		5. Social Security Number 6. Sex 215 94 3153	7. Age (<i>In yrs. Ia</i> : M 2□ F 25	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 22	Year) 9.	Birthplace (State or Foreign Country) Maryland
Sa-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor		Town or Loc	ltimore				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23a or 26	ai Dire	3704 Baltimroe	Street		10f. Zip Code 212.			U.S.	Country?
al', or itama :	by Funeral	11. Marital Status 1 TXNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1Yes 2 [X]No If Yes, Give Year or Dates:	İ	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 🙀 No	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		mencan Indian, Thite, etc. White
permit. Pages I and 2 should be filed within 72 flouts ariet deets with the wasyan bepartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be inclined at once.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0·12) 1 2 th	ation completed) College (1-4or 5+)	(Give	ent's Usual Occupat kind of work done di OO NOT use retired) OPET	ion uring most of work	ing	16b. Kind of Busine	ess/Industry Construction
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alth and M	-	19a. Informant's Name/Relationship (Type Bonnie Taylor / M			g Address (Street ar Condor La			r, City or Town, Stat nnsylvania	
reges 1 arent of Hesent:		20a. Method of Disposition 1 □ Rurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	movai from State		sition (Name of natory or other place en Mem. Pa		Date / 2005	20c. Location - City Glen Burr	or Town, State
permit. Departm importai any injui		21. Signature of Funeral Service License		22	. Name and Address	of Facility G	once Fur		rice, P.A. aryland 21225
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line. Lave Due to (or as a consequence)	ing	er the mode of dying	, such as cardiac	or respiratory ari	est,	Approximate Interval Between Onset and Death
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ite be executed lysicien and ne burial-transit	_	resulting in death) Last	Due to (or as a conseque	ence of);					
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Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a Date of Injury	ER/Outpatien 28b. Time of Injury	28c Inuny	at	ome 5 Resid	ence 6 ©Other (5	Specify:At Scene
itel or Attending urs efter death. iral Director: After lied in by the fune	Certification;	3 Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		Bre	OKLYNI	ed self r Aural Adule Number, b E. Patapsco An M.D.
To the Hospitel (within 24 hours elements) To the Funeral Discompletely filled i	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Examin	ician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death ion and/or in	n occurred at the tim- vestigation, in my op	e, date and place, inion, death occur	and due to the ored at the time.	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	ella u urd		29c. License			29d. Date signed (M August 29	
3		30. Name and address of person who cou				t Baltimo	ore. Mar	rvland 212	201

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) SEP 0 2 2005

JC 05-05829 Leamon Tyrone Bullock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ntal Hygiene 2005

or	State of Maryland / Department of Health and Men
tate egistrer	Certificate of Death

			Registrer					Cer	titicate	e of L	Death			Reg. No.	200	U	2011	i
			1. Decedent's Name	e (First, Midd	lle, Last)							2	Date of De				3. Time of Death	1
	Physici		Leamo	n Tyrone	Bullock								Month August	. 30			07:06 A	М
E	/Medic Examin		4a. Facility Name (I			number)			4b. City.	Town, or	Location of		14545		County of De		07.00 11	-
		eı	2300 At1			,			Balt									
			5. Social Security N		6. Sex	7 Ag	e (In yrs. last	hirthday)	If Under		If Under 24	4 Hrs. A	Date of Bir	th	9 R	idhnla	ce (State or Forei	ian
	Funeral Director		214-64-825		1 X M 2□ F		39	Yrs.	Months		Hours		. Date of Bir (Month, Da				ce (State or Forei	gri
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	and w		10a. State	10b. County	/		10c. City, T	own or Lo	cation							100	d. Inside City Limit	its
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	er de	by Funeral	11. Marital Status		Armed	Forces?	Ever in U.S.	13. 1	Yas Deced Yes, spec	of His	spanic Origi n, Mexican, I	Pu <i>er</i> to Ri	fy Yes or No can, etc.))-	 Race - An Black, Wh 			
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Maryland 21215-0036	hen ne.	E G	Elementary/Seco	ondary (0-12)	College	(1-4or 5	+)		OO NOT us	e reureu)								
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	and salth		Dawn M. Bu	11ock/Wi	ife			54	11 Fai:	rlawn	Avenue	Balt:	imore,	MD 21:	215			
Ž	of He		20a. Method of Dis	•	3 ☐Removal fro	- Class	20b. Place ceme	e of Dispo etery, cren	sition (Nam natory or oi	ne of ther place	a) !	Dat	te	20c. Lo	cation - City o	or Town	n, State	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow any Injury or other traumatic avant, the Modical Examinar must be notified at once.		21. Signature of Fu	ineral Service	License)	22	. Nam <i>e</i> an	d Addres	s of Facility							_
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8	- 5 -		23b. Was deceden in the past 12		1 ☐ Liv	e birth	2 🗌 Fetal de	ath 3	Ectopic pro					2	23d. Date of d Month		ay Year	
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Division of Vital Records, P.O.	Attanding Physician: The law requires that the death or death. octor: After this certificate has been signed by the atteby the funeral director, page 2 should be detached for the funeral director, page 2.	Physicia	Part II. Other signif		ione contribution to	donth b	ut not requitie	a in the co	ad a shain a sa		a in Dani I		220 Did t	laba saa u	na contributo	to the	course of death?	
Ś	igne bed	5	Part II. Other signi	ncant condit	ions contributing to	o death o	ut not resultir	ig in the ur	idenying ca	iuse give	n in Part I.						cause of death?	
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S	Attar dea ctor y the	fica	3 Suicide	6 Could	not be 28e. Pla	ice or Inj	ry - At home	, farm, str	et, factory	, office		28	f. Location (Street an	d Number or I	Rural F	Route Number,	_
É	lor A after Direct	Certification:	Homicide	GOIOII	bu	ilding, et	c. (Specify)	Par	6				City or To	wn, State	ZER A	Has	tic AVE	2
	spita lours nersi		29a. Certifier	1 ☐ Certifyi	ing Physician: To	the best	of my knowle	-	_	at the time	e. date and				and manner	as stat	ed.	
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	of thin of the o	₩ M	29b. Signature and	title of certific					29c	. License	number			29d. Dat	e signed (Moi	nth, Da	ly, Year)	
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DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and M Certificate of Death	lental Hygiei	ne 2005	28712
			Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Oral Brown	August 2	8 2005	12:55 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 22 South 4b. City, Town, or Location of Death University of Maryland Medical System Greene Street Baltimore, Maryland	4	4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth Mgnth, Day, Ya	9 Birthp	place (State or Foreign
	Director		096-88-1195 12m 20 42 Yrs.	Feb. 5, 1	163 Jamo	ilca, WI
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	e Man a-f sh lifted	ctor	New York Bronx New York			1 ☐ Yes 2 🗖 No
	with th	Dire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	itry?
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	
9	after or Iter	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify:	Rican, etc.)	Black, White,	etc.
21215-0036	within 72 hours after death with the Maryland jiene. r than "neturel", or Items 23e or 28a-f show the Medical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	165	Specify: Blo	ack
215	nin 72 In "nel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing	Kind of Business/Ind	rustry
	filed within Hygiene. ther than "	Com	12 O Dietary Aide		Health	٦
Maryland	e d la be	Be	1/:1	e (First, Middle, Maid	len Surname)	
aryl	2 should and Me is mark sumation	To	19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rura	al Route Number, Cit	y or Town, State, Ap	Code)
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		MS. Sonya Brown 660 Nereld Ave	. Bron	X, New 4	lor K 10466
Jore	Pages 1 nent of H int: If iter iry or oth	1 9	1 M Burial 2 □ Cremation 3 M Removal from State	1.	Lo ation - City or To	
Baltimore		1	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	12005 C	Jacendo	n, Jamaica
B	permit. Departr Import. any inj.		Aslph L. Russ Toseph L. Russ Fu	neral Ho	me, P.A. Md. 212	16
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	ii i	Immediate Cause (Final disease or condition a. Cerebravascube Accident resulting in death)			Onset and Death
	Examiner		Due to (or as a consequence of):			
\	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury			
d	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
9289	licate be executed physician and s the burial-transit	edlcal E	d			
_		Medi	IFFEMALE:			
Вох	death certifi e attending ed for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		23d. Date of delive Month	ry Day Year
P.O.	D 0 D	hysic	1 Yes 2 No 9 Unknown			
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to th	
ord	w requir been si should			1 X Yes	2 No 3 Prob	ably 4 □Unknown
of Vital Records,	9 4 9	Completed		24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of
ta	iician: Th certificate rector, pag	O	25. Was case referred to medical 26, Place of Death	1 Yes 2 X	Vo 1 ☐ Yes	2 X No
of V	d is	To B	the state of the s		6 □Other (Specify	7)
	ding Ph h. After th funeral	lon:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how ir	jury occurred	
Division	Attender deatlector:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		and Number or Rura	l Route Number,
D	itel or rs afte el Dir	Cert	4 Homicide building, etc. (Specify)	City or Town, St	170)	
	Hosp 24 hou Funei rely fill	edical	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a constant occurred on the passis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause ed at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Med	29b. Signature and title of certifier 29c. License number		Date signed (Month, L	
	1		Danie Novacia P18589		8/28/05	5
	14		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 MAIN AVE SW. GRA BUCKE MD 21061	Dans	Vovacic	
	∗ Sta	tė	31. Date filed (Month, Day, Year) SEP 0 2 2005 SEP 0 2 2005 SEP 1 2 2005 SEP 1 2 2005	UHNICAT	KOVACI C	
100	Registr		SEP 0 2 2005 Believe It 19			

			For	State of Maryla	•		Mental Hygie	ene	
			1 - State Registrar 1. Decedent's Name (First, Middle, Las	(1)	Certifica	ate of Death	Reg. 2. Date of Death	NOZUU5	28713
П	Physici		Clinton	Black	Mell	St	AMONTH	Day Year	9:55 A
Н	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4b. Cit	ry, Town, or Location of De	ath	4c. County of Death	
			5. Social Security Number 6. Si	n Ave.	. last birthday) If Und	Salt mov der 1 Year I if Under 24 H	rs. 8. Date of Birth	9 Birthr	place (State or Foreign
В	Funeral Director			QM 2□F 84	Yrs. Month		n. 8. Date of Birth (Month, Day, Y	921 VIC	ginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location		3 1	1	Od. Inside City Limits
	Maryl	tor	Maryland N/	7	Baltin	nore.			1 Yes 2 □ No
	or 284	Director	10e. Street and Number	1	10f. 2	Zip Code	10g	. Citizen of What Cour	ntry?
	ns 23e	Funeral	1/33 KUXTO	12. Was Decedent Ever in U	J.S. 13. Was Dec	cedent of Hispanic Origin? Decify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - America	
9	iurs after deeth with the Marylan alt', or items 23e or 28a-f show Exicalited and Let inclifted at		1 ☐ Never Married 2 1 Married	Armed Forces? 1 XYes 2 □ No If Yes, Give		pecify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White,	etc.
21215-0036	72 hours after deeth with the Maryland "natural", or items 23e or 28e-f show office! Exercit set? wat be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Decedent's Us	sual Occupation	16	b. Kind of Business/Ind	dCA
215	C 2 39	Completed	(Specify only highest gra		(Give kind of v	work done during most of v use retired)	vorking) (/:/	11 /
			17. Father's Name (First, Middle, Last)		LFORE	Man 18. Mother's N	ame (First, Middle, Mai	201110110	m Steel
land	e d at a	To Be	Daniel Blo	ckuell		Viol	a Verl	21/	
Maryland	and and is m		19a. Informant's Name/Relationship (ype, Print) (Son)	19b. Mailing Addre	ess (Street and Number or	Pural Route Number, C	ity or Town, State, Zip	Code)
-	1 an Heal em 2		20a. Method of Disposition	ackwell Jr	Place of Disposition (A	Devonsh	Date 20	c. Location - City or To	d 2/2/5
mor	of of		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	cemetery, crematory o	Forest 9/9	/2005 0	winas M	ilk Md.
Baltimore	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licen	500 Y	T	and Address of Facility	< Flineso	al Home	P.A.
	₫ D = 6 0		23a Part Enter the Mease or comp	dications that cused the dea	2227	W. North	ac or respiratory arrest	to, Maiz	Approximate
	Physician		23a. Parf. Enter the sease, or company of the sease, or company of the sease, or company of the sease or condition	one cause on each line.	tic one		ncer		Interval Between Onset and Death
П	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	3510010 00	11001		years
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Unionitying Cause (Disease or injury	b. Due to (or as a conse	quence of):				
	nd ransit	Examiner	triat initiated events	c					
8760,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
9		ledical		d					
Вох	eath certific attending p I for use as	Physiclan/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1□Live birth 2□Fet	al death 3 Ectopic			23d. Date of delive Month	Day Year
o.	at the de by the a stached f	nysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of 9□Unknown	death 5 ☐ Other ((specify)			
s, P	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	by PI	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobac	cco use contribute to th	
of Vital Records,	w require been si should I	eted					1 Yes	60 C	ably 4 □Unknown
Rec	The faw ate has t page 2 s	Completed					24a. Was an autopsy performed	d? death?	psy findings available mpletion of cause of
ital		Be Co	25. Was case referred to medical			26. Place of C	1 ☐ Yes 2 € eath (Check only one)	No 1 ☐ Yes	2 No
of V	Physician: r this certific ral director,	P	examiner? 1 Yes 2 No		☐ ER/Outpatient 3☐ I		Home 5 Residenc		y)
	fte or	tlon	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, factority)	ory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,
۵	e Hospitel or Attendi 24 hours after death. 9 Funeral Director: A elely filled in by the fu		29a. Certifier 19 Certifying Ph	ysician: To the best of my kn			1		hates
	To the Hospitel within 24 hours and the Funeral to completely filled	Medical	(Check only 2 Medicel Exam	iner: On the basis of examin and manner stated.	ation and/or investigation	on, in my opinion, death of	curred at the time, date	and place, and due to	the cause(s)
	To the hwithin 24 To the F	Ž	29b. Signature and title of certifier	1. /1	2	29c. License number	29d.	Date signed (Month,	Day, Year)
	1		30. Name and address of person who	dependence of death (to	or 23a) (Type Print)	VA# 13-115	20140000	1/1/D5 ER CENT	S.P.
					BA MD	22 S.	Greene S	St. Bill	rivare MD
	Sta Regist		31. Date filed (Month, Day, Year) SED 0 9 201	32 Registrar's Sign	nature Accept				21201

		For State Registrar		Department of Health and Certificate of Death	He	J. No.
Physici /Medic	an cal	1. Decedent's Name (First, Middle, Las John Joseth	Barrett		2. Date of Death Month	Day Year 3. Time of Death 22 2005 9:55 A M
Examin	ICI	4a. Facility Name (If not institution, I give Howard County Gene		4b. City, Town, or Location of Dea	ath (4c. County of Death Howard
Funeral Director		220-30-3379	7. Age (In yrs. last to 65	oirthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		year) 9. Birthplace (State or Foreign Country) Baltimore, MD
d show		Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, To	wn or Location		10d. Inside City Limits 1 Yes 2 No
3a or 28a at ke neti	Funeral Director	10e. Street and Number 5549 Bluecoat Lane	2	10f. Zip Code 21045	US	g. Citizen of What Country?
ir health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-1 ehow other traumatic event, the Medical Examilier Logal Ke notified at	2	11. Marital Status 1 ☐ Never Married ②☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 YN o If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2XXNo Specify:	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
"natur edical	Completed	15. Decedent's Ed (Specify only highest grad	ucation 16 de completed)	ia. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking	6b. Kind of Business/Industry
er than	Somp	Elementary/Secondary (0-12)	College (1-40r 5+)	abor Relations Speci		ederal Government
Is marked other than aumatic event, the M	To Be (17. Father's Name (First, Middle, Last) John Barrett, II		Mary Ro		
n 27 Is m ner traum		Doris O. Barrett	(wife) 5	9b. Mailing Address (Street and Number or I 549 Bluecoat Lane	Columbia,	MD 21045
<u>=</u> 5		20a. Method of Disposition *AZBurial 2 □ Cremation 3 □ *4 □ Donation 5 □ Other (Specify	Removal from State	of Disposition (Name of tery, crematory or other place) Redeemer Cemetary 08		Baltimore, MD
any Injury once.		21. Signature Funeral Service Licen	589/	22. Name and Address of Facility W		
ician dical dical niner	icai Examiner	shock, or heart failure. List only of lamediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any locating to minor allocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	a of):	1 .	Onset and Death
ası	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ched for use	1 ys				23e Did tobs	cco use contribute to the cause of death?
be detached	by	Part II. Other significant conditions of	ntributing to death but not resulting	in the underlying cause given in Part I.		2 No 3 Probably 4 Unknown
ate has been sign page 2 should be	by	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.	1 ☐ Yes	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of
ate has been signed by the page 2 should be detached	Be Completed by	25. Was case referred to medical examiner?	Hamital	26. Place of D	1 Yes 24a. Was an autopsy perform 1 Yes 2	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
fler this certificate has been signed by the ineral director, page 2 should be detached	To Be Completed by	Hypothypoid 25. Was case referred to medical examinar?	Hospital: 1 Inpatient 2 FR/0 28a. Date of Injury (Month, Day Year) 28b	26. Place of D	1 Yes 24a. Was an autopsy perform 1 Yes 2	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No ce 6 Other (Specify)
fler this certificate has been signed by the ineral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year)	26. Place of D Outpatient 3 DOA Time of Injury M 26. Place of D Other: 4 Nursing Work? 1 Yes 2 No	1 U Yes 24a. Was an autopsy perform 1 Ves 2 eath (Check only one Home 5 Residen 28d. Describe how	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No No 6 Other (Specify) Injury occurred
fler this certificate has been signed by the ineral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	26. Place of D Outpatient 3 DOA Time of Injury M 26. Place of D Other: 4 Nursing Work? 1 Yes 2 No	24a. Was an autopsy perform 1 Yes 2 eath (Check only one Home 5 Residen 28d. Describe how 28f. Location (Stre. City or Town.	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No No ce 6 Other (Specify) Injury occurred State) ses(s) and manner as stated.
fler this certificate has been signed by the ineral director, page 2 should be detached	Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 FR/0 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) visician: To the best of my knowled iner: On the basis of examination in	26. Place of D Outpatient 3 DOA Other: 4 Nursing Time of Injury M 1 Yes 2 No farm, street, factory, office	24a. Was an autopsy perform 1 Yes 2 eath (Check only one Home 5 Residen 28d. Describe how 28f. Location (Stre City or Town, ce, and due to the caucurred at the time, dat	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No No ce 6 Other (Specify) Injury occurred State) ses(s) and manner as stated.
ate has been signed by the page 2 should be detached	edical Certification; To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 FR/0 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) visician: To the best of my knowled iner: On the basis of examination and manner stated.	26. Place of D Outpatient 3 DOA Other: 4 Nursing Name of Very 1 Yes 2 No farm, street, factory, office 10ge, death occurred at the time, date and plae and/or investigation, in my opinion. death occurred at the time of the	24a. Was an autopsy perform 1 Yes 2 eath (Check only one Home 5 Residen 28d. Describe how 28f. Location (Stre City or Town, ce, and due to the caucurred at the time, dat	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ce 6 Other (Specify) r injury occurred let and Number or Rural Route Number, State) se(s) and manner as stated. e and place, and due to the cause(s)

DHMH 17 Rev 1/2001

2005

AUGUST

LORETTA BACH

			For Amend Items	State of Maryla	and / Depa	artment of J	lealth and	Mental Hyg	iene		
	Physicia /Medic		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar State of Maryland / Department of Health and Mental Hygiene 23a,25,27,28a-f.per.MF.G8/1/09/01/05dhb Reg. No. 2005 287 [6] 1. Decedent's Name (First, Middle, Last) // 2. Date of Death 3. Time of Death 3. Time of Death 3.								
		al	Michae	/ Conn.	elly			Month 8	Day 9 Year	6:40p M	
	Examin		4a. Facility Name (If got institution, give	street and number)	650	4b. City, Town, or	Location of Dea	MA	4c. County of Deat	h	
d	Funeral		5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr. Hours Min	S. 8. Date of Birth (Month, Day,		hplace (State or Foreign untry)	
Ţ.	nit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland contains of Health and Marhall Hyginan forthers it flem 72 is marked other than "natural", or thane 23a or 28a-f show injury or other treumatic event, the Marical Eventual be notified at injury or other treumatic event, the Marical Eventual be notified at 25a.		5. Social Security Number 6. Sex 1 M 2 F 50 Yrs. 7. Age (In yrs. last birthday) 1 Months Days 1 Months Days 1 M ARCH 30, 195 9. Birthplace (State or Foreign (Month, Day, Year)) 1 M ARCH 30, 195 9. Birthplace (State or Foreign (Month, Day, Year)) 1 M ARCH 30, 195 9. MARYLAND							MARYLAND	
CA		5							10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
		Funeral Director	MD BALT	IMORE	ESSI	10f. Zip Code		11	0g. Citizen of What Co	untry?	
		ralD	318 NICHOLSON		U.S. 13. Was Decedent of Hispanic Origin? (Specify Ye if Yes, specify Cuban, Mexican, Puerto Rican,			U.S.			
			11. Maritat Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (an, Mexican, Pue Specify:	rto Rican, etc.)	Black, Whit		
		leted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wi	orking	16b. Kind of Business/	Industry	
		Completed by	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)						G	
		Be	17. Father's Name (First, Middle, Last)	U COMMETTS	v TD	•		ame (First, Middle, Λ			
Maryland		2	FRANCIS JOSEPH CONNELLY, JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						Zip Code)		
	and 2 leatth a m 27 is		LINDA SHUSTA/S		3008		ROAD, PA		MARYLAND 20c. Location - City or		
nore	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crei	CREMATO				, MARYLAND	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		21. Signature of Funeral Service Licen		3	2. Name and Addre	ss of Facility ZEILER	INC. FU	JNERAL HO	ME 21231	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed XB within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Director: After this certificate has been signed by the attending physician and Director in Director, page 2 should be detached for use as the burial transit.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Narcotic and a cohol intoxication Approximate Interval Between Onset and Death								
7			Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):							
		Examiner	Sequentially list conditions,	b							
			d any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):							
,092		i Exa	resulting in death) Last	d. Due to (or as a consequence of):							
n of Vital Records, P.O. Box 68		edical		d							
		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of del Month	ivery Day Year	
		by Ph	Part II. Dther significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tob	23e. Did tobacco use contribute to the cause of death?		
		eted	allonsti						1 Yes 2 No 3 Probably 4 Unknown		
		Completed						_ perforn	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No		
		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
		은	1 XYes 22 No.	Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?							
		Medical Certification:	1 Statural 5 Pending investigation of 3 Suicide 6 Could not 1	n Found 7/28/ Unknown ^M 1 Yes 2X No			Unknown				
Divis			3 ☐ Suicide 6X Could not be determined	building, etc. (Sp.	e. Place of Ind. Thome, farm, street, factory, office building, etc. (Specify) Found at home			28f. Location (Street and Number or Rural Route Number, City or Town, State) Found: 318 Nicholson Rd., Essex, MD			
			29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	(1)		30. Name and lodgress of person who completed cause of death (Item 23a) (Type, Print) Howard Steiner 5601 Coch Raven Blvd								
	<u>.</u>		Howard	Steine	5	601 C	och	Ravec	n Blud		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Si	Same?						

ORIGINAL

DHMH 17 Rev 1/2001

/Med	ian	1 - State Amend Item 1 Registrar 1. Decedent's Name (First, Middle, Last	Dai Dai a CO	usins			2. Date of Dea	Day Year	3. Time of Death
	ical	4a. Facility Name (If not institution, give	etraat and aumber!		4h City Town	or Location of De		4c. County of Dea	J
Exami	ner	11	reland		12.14	Abre	201	n/a	uı
Funeral		5. Social Security Number 6. Se		. last birthday,	If Under 1 Year Months Days	If Under 24 H		h 9. Bir	thplace (State or Foreign
Director		133-44-0795	^{3 м 2} Д F 54	Yrs.	Months Days	TIOUIS IVII			w York
*		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
f eho	jo	Maryland Anne Aru	- 101	0.6	lantan				1 ☐ Yes 2 📉 No
r 28a	Director	10e. Street and Number	nger	0	10f. Zip Code			10g. Citizen ol What Co	ountry?
23a o	a D	701 Harvest Run D	rive		2	1113		United	States
tems ELM	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
, or	by F	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 □Yes 2X No II Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	Black
atural		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business	
Media	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w ad)	rorking		
al Hygien other the	Completed	12th		Exe	cutive S			Government	Security
od oth even	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,		
and Mental Is marked raumatic ev	2	Charles Cou	sins	19b Mail	ng Addrose (Strag	Euger		Williams or, City or Town, State, 2	Zin Coda)
Ith an	1	Charlotte Summers	_		Thicket		_	Maryland 2	
it of Health and Mental Hygiene. It flem 27 is marked other then "natural", or items 23s or 28s-f ehow or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b.	Place of Disp	osition (Name of matory or other pla		Date	20c. Location - City or	
nent of l ant: tf lte ury or o		1 MBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	komont	Memorial	Gardens	/2005	Davidsonvil	1e≅ MD
Department of Importent: to eny injury or once.		21. Signature of Funeral Service Licens		2	Name and Addr	ess of Facility			
8 = 8	4	Quanta Ry	nomas Mo	$0957 \stackrel{\text{Do}}{12}$	naldson 11Annapo	Funeral lis Road	Home & Ci l Odenton	rematory, P , Maryland	21113
		23a. Part1 Enter the disease, or composhock or heart failure. List only o	ications that caused the dea ne cause on each line.						Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Hepatocelli	ilar (arcino	na			Onset and Death
edical miner	_	resulting in death)	Due to (or as a conse	quence of):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):					
ansit	Examiner	cause. Enter Underlying Cause (Disease or injury							
en an rial-tr		resulting in death) Last	Due to (or as a conse	quence of):					<u> </u>
ohysicien and the burial-transit	Physician/Medical	(d						
attending ph I for use as t	Med	IF FEMALE:	12a Huna autama af aram						
attenc for us	ian	in the past 12 months?	23c. If yes, outcome of pregression 1 ☐ Live birth 2 ☐ Felder 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnanc	у		23d. Date of de Month	ivery Day Year
the the	iysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	Geath 5	_ Other (specify) _				
ned by detac	by Pr	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
been sign should be							101	res 2.2 No 3 □ Pr	obably 4 Unknown
as been 2 shoul	plet						24a. Was	an 24b. Were au	utopsy lindings available completion of cause of
e h	Completed						autop perfo 1 ☐ Yes	rmed? death?	2 No
	Be C	25. Was case referred to medical examiner?				26. Place of D	eath Check only o	ne	
	2	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	_	IL SEL DOA			dence 6 ☐Other (Spe	cify)
s certific director,		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ıryat ork?]Yes 2∐No	28d. Describe h	now injury occurred	
s certific director,		investigation	1				28f. Location (S	Street and Number or Ru	ural Route Number
tor: After this certific the funeral director,		2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	nome, tarm, si	reet factory office				
tor: After this certific the funeral director,	ertification:	Z L Accident	28e. Place of Injury - At building, etc. (Spec	nome, farm, st	reet, factory, office		City or Tov	iii, oldio)	
tor: After this certific the funeral director,	Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Spec sicien: To the best of my kr	nowledge, dea	h occurred at the t	me, date and pla	ce, and due to the	cause(s) and manner as	s stated.
Funeral Director: After this certific ely filled in by the funeral director.	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phyone)	building, etc. (Spec	nowledge, dea	h occurred at the tovestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
Funeral Director: After this certific ely filled in by the funeral director.	ertification:	3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	building, etc. (Special Special nowledge, dea	h occurred at the tovestigation, in my	me, date and pla	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Mont	s stated. It to the cause(s) The Day, Year)	
4 hours after deeth. Funerel Director: After this certific ely filled in by the funeral director,	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier Check only one) 29b. Signature and title of certifier	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	h occurred at the tivestigation, in my	ime, date and pla opinion, death oc se number + 6 7 2	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Mont	s stated. to the cause(s) h. Day, Year)
leeth. tor: After this certific the funeral director,	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phyone)	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, dea nation and/or in em 23a) (Type	h occurred at the tivestigation, in my	ime, date and pla opinion, death oc se number + 6 7 2	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Mont	s stated. to the cause(s) h. Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - For State of Registrar	Marylan			f Health a of Death		ental Hygi	ene g. No. 20 () 5	28718
	Physici /Medic				ERTRUD	E COOPE			2. Date of Death Month Aug 26,	2005	Year	3. Time of Death 1:30 PM
	Examin		4a. Facility Name (If not institution, give street and num. Genesis Eldercare – Ha	mmonds		Ba1	m, or Location			Anne Arundel		
	Funeral Director		5. Social Security Number 218−18−4301 6. Sex 1 □ M 2 🖫 F 7	. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under ays Hours	Min.	B. Date of Birth (Month, Day, Jan 30,	1922	9. Birthpi Coun Mary	ace (State or Foreign try) Land
	Maryland I-f show	tor	10a. State 10b. County Maryland N/A	10c. Cit	y, Town or Lo Balti			5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -			10	Od. Inside City Limits
	as or 28e	i Director	10e. Street and Number 600 Light St.	, #412		10f. Zip Coo	21230)	10	g. Citizen of W USA	hat Coun	try?
980	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Macical Examiner must be natified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes Girls Status 12. Was Deced Amed Ford 1 Yes Sive Yes of Da	es? 2 🙀 No		Was Decedent f Yes, specify (1 ☐ Yes 2 ∏			cify Yes or No- Rican, etc.)	Black	- Americ , White, o	etc.
21215-0036	=	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+)	(Give	DO NOT use re	one during mos)g	6b. Kind of Bus		ital Ctr.
Maryland 2	be filed ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) Hugh A	lbert N	Neill				(First, Middle, Meana Mul.			
	ss 1 and 2 should of Health and Men item 27 is marke r other treumatic		19a. Informant's Name/Relationship (Type, Print) Neill J. Sewell (Son)		1				Route Number, Ltimore,			Code) 21229
Baltimore,	00-		20a. Method of Disposition 1 [X] Burial 2 □ Cremation 3 □ Removal from S 14 □ Donation 5 □ Other (Specify)	tate Wes	emetery, cren stern (sition (Name o matory or other Cemeter	place)	B/28/0		oc.Location - 0 altimor	-	_{wn, State} aryland
Balt	permit. Pag Department Important: I any Injury o		21. Signatur of Furleral ervice Licensee Kevin	E Eck	1 1	Name and Active 130 E.	dress of Facili Polyni Fort Av	ak Fi	uneral H Baltimor	ome, P. e, Md.	A. 212	30
3	Pnysician		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	ch line.		- 1	dying, such as			st,		Approximate Interval Between Onset and Death
8760,	Medical Examiner physician end the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Finite underlying Cause (Disease or injury that initiated events c.	r as a conseq	uence of):							
.O. Box 6	The law requires that the death certifics tie has been signed by the attending pt tage 2 should be detached for use as It	Physician/Med		th 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pregna Other (specif)				23d. Date Mon		ry Day Year
<u>α</u>	w requires that been signed by should be deta	þ	Part II. Other significant conditions contributing to dea	ath but not res		nderlying cause	•			_		e cause of death? ably 4 Unknown
al Records,		Completed							24a. Was an autopsy perform 1 Yes 2	ed? pr	for to consath?	sy findings available apletion of cause of
f Vital	Physicien: This certifical director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 In	patient 2	ER/Outpatien	t 3 DOA	Othor	of Death ursing Hom	(Check only one ne 5 ☐ Resider) ice 6 □Othe	r (Specify)
ion of			27. Manner of Death 1 Matural 5 Pending investigation 2 Accident (Month	Injury , <i>Day Year)</i>	2Bb. Time of Injury		Injury at Work? 1 □ Yes 2 □		8d. Describe hov	v injury occurre	d	
Division	in d	Certification;	3 Suicide 6 Could not be 4 Homicide determined 2Be. Place of buildin	of Injury - At hog, etc. (Specif	ome, farm, str	eet, factory, off	fice	2	8f. Location (Stre City or Town,		r or Rurai	Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier 1 Certifying Physician: To the la (Check only one) 2 Medical Examiner: On the ba and mann	sis of examina	wiedge, death tion and/or in	vestigation, in r	my opinion, dea	nd place, a ath occurre	d at the time, dat	e and place, a	nd due to	the cause(s)
	To Toon	2	29b. Signature and title of confider	·-	m		B 701	-15		d. Date signed		
_	Z '		30. Name an digress of person who completed cause	i in	n 23a) (Type,	Print)	FUT.	Fre	, Bal+	nire	N	9,2005
	Sta Registr		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signa	Apr	Si.			,	•		

Medical Examiner Mineral Exa	N/A 9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Yes 2 No What Country? S.A. 9. American Indian, k, White, etc. White siness/Industry ers Local 557
WILLIAM FRANK CRAMER SR. A G G Z 7 2	of Death N/A 9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Yes 2 No What Country? S.A. 9. American Indian, k, White, etc. White siness/Industry ers Local 557
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County or School Co	N/A 9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Yes 2 No What Country? S.A. 9. American Indian, k, White, etc. White siness/Industry ers Local 557
Funeral Director Funeral Director S. Social Security Number 156-16-4759 6. Sex, 126-16-4759 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 10 M 2 F 78 Yrs. Months Days Hours Min. Dec. 17, 1926 11 M 2 F	9. Birthplace (State or Foreign Country) New Jersey 10d. Inside City Limits 1 Yes 2 No What Country? S.A. 9. American Indian, k, White, etc. White Isiness/Industry 10d. Inside City Limits 1 Yes 2 No
Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Pasadena 10d. Zip Code 21122 11. Marital Status 1	New Jersey 10d. Inside City Limits 1
Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	ors Local 557
To be to the state of the state	vhat Country? S.A. e- American Indian, k, White, etc. White siness/Industry ers Local 557
To be to the state of the state	what Country? S.A. American Indian, k, White, etc White white white siness/Industry Local 557
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To be to the state of the state	k, White, etc. White siness/Industry ers Local 557
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To be to the state of the state	rs Local 557
To be to the state of the state	
The state of the s	
William 1. Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stein (Daughter) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stein (Daughter) 702 211th Street, Pasadena, Maryland 2	a)
Cathy Stein (Daughter) 702 211th Street, Pasadena, Maryland 2	State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	City or Town, State
20a. Method of Disposition Comparison C	nie, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryla	and 21122
23a. Pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Physician Physician	Approximate Interval Between Onset and Death
/Medical Examiner LUNG CANCER	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
To a state of the	
	<u> </u>
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	e of delivery nth Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions	bute to the cause of death?
So to to to to to to to to to to to to to	3 ☐ Probably 4 ØUnknown
24a. Was an 24b. W pr autopsy performed? de	Nere autopsy findings available prior to completion of cause of leath?
25. Was case referred to medical examiner? Hospital: Other:	
Se se le le le le le le le le le le le le le	
27. Manner of Death 27. Manner of Death 1. Matural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1. Natural 5 Pending (Month, Day Year) 4. Natural 5 Pending investigation	ad
E TO CO TO ACCIDENT	er or Rural Route Number,
29a. Certifier Check only 29a. Certifier (Check only Check only Check only Check only 29a. Certifier Check only Check	
č C č Ō d)	i (Month, Day, Year)
end and manner stated. 29c. License number 29d. Date signed	7 200-
29b. Signature and title of certifier 29c. License number 29d. Date signed AVG, 2	7 2005
29b. Signature and title of certifier 29c. License number 29d. Date signed DO059190 AUG, 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEORGE BAFFOE BONNIE, ST. AGNES HOSPITAL, 13.	

アノノイトノタア

Physician Month Month AUGUST A	rginia ide City Limits Yes 2□No idan, ee
August A	State or Foreign Tginia ide City Limits Yes 2 \(\text{No} \) ian,
NEMORIAL HOSPITAL S. Social Security Number S. Socia	rginia ide City Limits Yes 2□No idan, ee
Social Security Number S. Social Security Number S.	rginia ide City Limits Yes 2□No idan, ee
Director 233-68-1476 63 10c. Cley, Town or Location 10d. Institute 10d. Institu	ide City Limits ¶Yes 2 □ No ian, ee
10a State 10b County 10c City, Town or Location 10d Ins	Yes 2□No ian, ee
David Franklin Ritchie September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ian, : e
David Franklin Ritchie September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ate
David Franklin Ritchie September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ate
David Franklin Ritchie September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ate
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David Franklin Ritchie September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ate
David Franklin Ritchie September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	ate
1 ABurial 2 Cremation 3 Removal from State Dawson Cemetery 2005 Dawson, Mary	ate
1 ABurial 2 Cremation 3 Removal from State Dawson Cemetery 2005 Dawson, Mary	ate
1 ABurial 2 Cremation 3 Removal from State Dawson Cemetery 2005 Dawson, Mary	
Physician /Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate Due to (or as a consequence of):	and_
Physician /Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate Due to (or as a consequence of):	
Physician /Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate Due to (or as a consequence of):	
Physician Medical Immediate Cause (Final disease or condition resulting in death)	oximate ral Between
Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Non-Insulin Dependent Diabetes Due to (or as a consequence of):	t and Death
Sequentially list conditions, if any, leading to immediate by consequence of):	
Causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Essential Hypertension Due to (or as a consequence of):	215
Due to (or as a consequence of).	LFS
₹ 0 .02 5 1	
dical E	
IF FEMALE: 23c. If yes, outcome of pregnancy 1	
23b. Was decedent pregnant in the past 12 months? 1 Ure birth 2 Fetal death 1 Ure birth 2 Fetal death 5 Uther (specify) Month Day	Year
o e t t d y age	
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the caus	
1 Nes 2 No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 1	dings available
performed? death? 1 yes 2 1 No 1 yes 2 0 N	
1 Yes 2 No 1 Yes 2 No	
1 Inpatient 2 PLEM 705 2 NO 1 Inpatient 2 PLEM 700 1 Normal Plem 8 Norma	
28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
28a. Date of Injury 28b. Time of Lost Work? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3 Number,
	Pusa(s)
29a. Certifier 1 29c. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)	7
	ear)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ear)
LEE, KENNETH, M.D., 902 SETON DRIVE, SUITE 204, CUMBERLAND, MD 21502	(ear)
State Registrar SEP 0 2 2005 32/Registrar's Signature	(ear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Marytand / Deparation of the Registrer Cert	tificate of D	eath		No. 2005	28721
ı	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Eldine Childs			2. Date of Death Month AUG. 25	Day 2005 Year	3. Time of Death 1219 P M
	/Medio Examin		4a. Facility Neme (If not institution, give street and number) 3730 COLUMBUS DRIVE	4b. City, Town, or L BALTTMO	ocation of Death		4c. County of Dear	th
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign
	Director		Usual Residence of Decedent			Jan. 26	,1947 M	aryland
	Marylar -f show lind	tor	10a. State 10b. County 10c. City, Town or Loc Balt:	imore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	ii Direc	10e Street and Number 3730 Columbus Drive	10f. Zip Code 21215			Citizen of What Co	ountry?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show apply flury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2√2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Madical	ompieted	(Specify only highest grade completed) (Give kilder) Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupati kind of work done du NOT use retired) emaker	ion ring most of work	ing	n Home	Andustry
nd 2	be filled ta! Hygi d other event,	Be	17. Father's Name (First, Middle, Last)	1		e (First, Middle, Maid		
aryla	should ind Men marke umatic	To	John A. Childs 19a. Informant's Name/Relationship (Type, Print) Towanda D. Cottman/Daughter 371					Zip Codel 2 0
	1 and 2 Health a om 27 ic		Towanda D. Cottman/Daughte 371				more, Ma	
Baltimore,	Peges ment of ent: if it ury or o		1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemeter Cemeter	y 8/3	0/05 Ba	ltimore	,Maryland
Balt	permit. Departimonts Import		21. Signature of Funeral Servic Livensee 22.	Name and Address	of Facilit©ha cerstow	tman-Har n Rd Bal	ris Fun timore,	eral Home Md 21215
			23a Dant . Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death) a. Athewsclewate care pure to (or as a consequence of):	diovascul	ardise	gce		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			•		
4	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
68760,	ate be e hysiciar the buris	Aedicai E	d					
.O. Box 6	death cer e ettendir id for use	by Physician/Med		Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Δ.	The law requires that the site has been signed by the bage 2 should be detache	d by Pt	Part II. Other significant conditions contributing to death but not resulting in the unit Diabetes Mellutus	derlying cause given	in Part I.	23e. Did tobacc	_	o the cause of death?
Vital Records,	law requir as been sl e 2 should l	Completed				24a. Was an autopsy	24b. Were au	itopsy findings available completion of cause of
tal F		Be Cor	25. Was case referred to medical		26. Place of Deat	performed 1 Yes 2	7 death? No 1 ☐ Yes	2 No
of	Jing Pl	္	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	3 DOA Other: 28c. Injury a Work?	4 Nursing Ho	me 5 Residence 28d. Describe how in		cify) AT SCENE
Division	i or Atter after dea Director i in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office		28f. Location (Street City or Town, St		ıral Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigated.	occurred at the time, estigation, in my opin	, date and place, nion, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License r			Date signed (Monti	
	2		30. Name and address of per who completed cause of death (Item 23a) (Type, P	O.C.P	7 • E		AUG. 25	,2005
			Tasha Z Greenberg M.O. 111 PENN	•	BALTIMORI	E,MARYLAND	21201	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ade				

			For State Registrar	=	epartment of Health and I Certificate of Death	Mental Hygien	711115 78177
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia /Medic		Kenneth W. (Cross			005 Year 7:09 P M
	Examin		4a. Facility Name (If not institution, give si		4b. City, Town, or Location of Death		c. County of Death
			Southern Maryl		Clinton		Prince George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Davs Hours Min.	(Month, Day, Yea	St Cost S M =
	Director		220 28 6930 XX	12		Nov 29,	1932 St. Louis , Mo
	/land		10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
	Many	ţo	Maryland Prince (George's Cli	nton		1 □ Yes 2 □ No X
	th the	Director	10e. Street and Number		10f. Zip Code	10g. 0	Citizen of What Country?
	23a c		7721 Surratts		20735		ited States
	tems	Funeral	11. Maritar Otatos	Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fi	1 ☐ Never Married X X X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☆Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
ဝို	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, It is Madical Examinat must be notified at	edt	15. Decedent's Educ	ation 16a. D	AA ecedent's Usual Occupation		Kind of Business/Industry
212	72 nin 72 an " m	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wor fe. DO NOT use retired)		
2	giene giene er tha	Completed	12/		ilder		nstruction
g	al Hy d oth	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	en Sumame)
yla	Meni Meni arke	은	Arville B. C			Anne Sevick	
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Typ		lailing Address (Street and Number or Ru		
e,	1 and Healt em 2: ther		Myra C. Cross (W	77 (20b. Place of D	21 Surretts Road, (sposition (Name of crematory or other place) Sept 6	linton, MD	20735 Location - City or Town, State
no	ages int of t: If it		1 Deurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State Resurr	ection Cemetery	, 2005	inton, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show amy injury or other traumatic event, It is Madical Examinat must be nutified at ance.		21. Signature of Funeral Service Users		22. Name and Address of Facility Lee		
B	Depar Impo any ir		1 flat Wort	- MOOIS3	Alexandira Ferry F	Rd. Clinton	MD 20735
	.*		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do no	enter the mode of dying, such as cardiac		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	SAME AND AND AND AND AND AND AND AND AND AND	bowel		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of)			
	Examiner	L	Sequentially list conditions, b				
7	ed sit	Jine	if any, leading to immediate cause. Enter Underlying Cause (Lisaase or injury) that initiated events	Due to (or as a consequence of)	:		
6	xecut and	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of)	:		
8760,	icate be executed physician and s the burial-transit	dical E	C				
9	ifficat g phy as the	ledi					
Вох	eath certific attending p	N/UE	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
	e deal	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death	5 ☐ Other (specify)		Month Day Year
<u>Р</u> .	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not resulting in t	no undorhina cauca gwoo in Part I	23e Did tobacc	o use contribute to the cause of death?
	ires tha signed I be del	by	Fait II. Other significant conditions con	mouning to death but not resulting in t	io undonying cause given in rain.		2 No 3 Probably 4 □Unknown
Records,	w require been si should I	Completed				24a. Was an	24b. Were autopsy findings available
Rec	has ge 2	mp				autopsy performed	prior to completion of cause of death?
		e Co	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 🔼 I ath (Check only one)	No 1 ☐ Yes 2 ☐ No
Vital	Physician: r this certific ral director,	To B	eyaminer?	lospital:	Othor	forme 5 ☐ Residence	6 ☐Other (Specify)
o	g Phy ier thi		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how in	
Ö	Attending r death. ector: After by the fune	atio	1 Natural 5 Pendin investing tion	(, 02)	M 1 ☐ Yes 2 ☐ No		
Division of	r Atter de irecte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	urs af urs af eral D		20. O. 18.	dates. To the blink of our local and one	Cart Carrier to the November and State	and due to the source	(a) and a parties on attack
	Hos 24 ho Fund etely f	edical	29a. Certifier (Check only one) Certifier 2 Medi al Examir	ner: On the basis of examination and/ and manner stated.	death occurred at the time, date and plac- or investigation, in my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Med	29b. Signature and title of certifier	1	29c. License number		Date signed (Month, Day, Year)
	, 7				D28639		7-1-05
	1		30. Name and address of person who co				
				irin, M.D. 7501 St	rratts Road Suite	303, Clinto	on, MD 20735
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	0244		
-	negisi	rui _	DE: 0 11 5000	Janes de la la la la la la la la la la la la la			

			For Stete Registrar	State of M	aryland /	Depa	artmen <i>rtificati</i>	t of H e of L	ealth a Death	and M	ental Hygi	iene 0	05	28723
	D		1. Decedent's Name (First, Middle,	Last)							2. Date of Death		Year	3. Time of Death
	Physicia /Medic			Mary Cho	rnyei						August	30	2005	5:45 P.M
	Examin	er	4a. Facility Name (If not institution, g	· · · · · · · · · · · · · · · · · · ·			4b. City,		Location of			4c. County		1 1
			Genesis Elder 5. Social Security Number 6		nds Lan		If Under		ltimo		R Data of Righ	Anne	Aru	
	Funeral Director		217 16 4638	1 M 2 1 F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Aug. 13	, 1915	9. Birth	place (State or Foreign ntry) aryland
	ס		Usual Residence of Decedent								1105. 13	, 1717		
	anylan show	_	10a. State 10b. County		10c. City, To								1	10d. Inside City Limits
	8a-1 s	cto		Arundel	Ва.	1tim								1 Yes 2 No
	with ti	Dir	10e. Street and Number 614 Hammonds	Lano			10f. Zip	212	25		10	g. Citizen of U.S		ntry?
	leath ns 23	Funeral Directo	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Deced			gin? (Spe	cify Yes or No-			can Indian.
9	after or itar		1 XNever Married 2 Marrie	Armed Forces						, Puerto F	cify Yes or No- Rican, etc.)		ck, White,	
8	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 Yes	ZLOJNO	Specify:			Specif	y: Whi	.te
<u>.</u>	"natu	lete	15. Decedent's (Specify only highest		16	6a. Dece (Give	dent's Usua kind of wor DO NOT us	d Occupa	ition lu <i>ring m</i> ost	of working	ig 1	6b. Kind of B	usiness/In	dustry
7	filed within 72 hours after death with the Maryland Hygiene. Hysithar than "natural", or Itams 23a or 28a-f show ant, Ita Mcalcal Eran Itac Frank Le mulliked at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Che:		ie reineu,	,			Pr	ivate	<u> </u>
פַ	m - 0 =	Be C	17. Father's Name (First, Middle, La	ist)					18. Mothe	r's Name	(First, Middle, M	faiden Suman	ne)	
/lar	2 should be filed within 72 hours after death with the Marylan and Mendal Hygiene is and Mendal Hygiene is marked to Hygiene is marked to 128e-1 show is marked out than "natural, or itams 28e or 28e-1 show aumatic event, it is Medical Erair free mast be notified at	To B	Paul	1 Chornyei					I	Mary	Schocec	k		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship	o (Type, Print)						_	Route Number,			
e,	1 and Health am 27 thar tr		Kay McAlpin 20a. Method of Disposition				Hammon			THE	timore,	Mary L. Oc. Location		
nor	S to to		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from State			osition (Name matory or o .edra1		- 1	9/2/2			-	Maryland
altimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lig		New	-	2. Name an				nce Fune			
ñ	Dep Imp any		+ Hono (lario	lose	4	001 R	itch	ie Hi					land 21225
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	the one called on each	ina									Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	ARTE	21050	EL E	NOT	(C	CAV	LDIC	DIASC	UCAR		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):					100	2492	E	
	99.5	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	а сопечения	se of):								
/	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o O	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequenc	ce of):								
8760,	cate be executed physician and the burial-transit	dicai		d.										
9 X	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy							234 Da	te of delive	200
Вох	death a atten	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal dea	ath 3[□Ectopic pr □ Other (sp					1	onth	Day Year
P.O.	t the c by the	hys	9 Unknown	9□ Unknown										
	res that the de signed by the a be detached f	by P	Part II. Other significant condition		out not resulting	g in the u	inderlying c	ause give	n in Part I.					ne cause of death?
ord	w require been si should t	ted	DEMENT								1 \ Ye	s 2 No	3 Prob	pably 4 🗹 Unknown
Sec.	has b	Completed	EMITHYS	EMA							24a. Was an autopsy perform	, ,	Were auto prior to co death?	psy findings available mpletion of cause of
a											1 ☐ Yes 2	2No	1 Yes	2□ No
=	sicial certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №	Hospital: 1 ☐ Inpati	ant 2 🗆 EB#	Outpotio	nt 3□ DC	Othe			(Check only one		(0:	
0	Attanding Physician: r death. actor: After this certific: by the funeral director.	\vdash	27. Manner of Death	28a. Date of Inj. (Month, Da		o. Time o		8c. Injury Work			8d. Describe how			y)
jo	ttandin death. tor: Aft the fun	atlo	1 Natural 5 Pending 2 Accident investiga	tion	ty 1 Gai)	Injury	М		r ∕es 2□l	No				
Division of Vital Records,	I or Attano after death Diractor: I in by the	Certification;	3 Suicide 6 Could no determin	200. Flace of III	jury - At home, tc. <i>(Specify)</i>	, farm, st	reet, factory	, office		2	8f. Location (Str. City or Town,	eet and Numb State)	er or Rura	Il Route Number,
Ω	pitel c		200 Cartillar 15 Cartifular	Dhysisians To the best	-6	4 4	h		- 4-4	4-1				
	To the Hospitel or At within 24 hours after of To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 Certifying (Check only 2 Medicel Ex	Physicien: To the best ceminer: On the basis of and manner s	of examination	and/or in	n occurred vestigation,	in my op	e, date and pinion, deal	d place, a th occurre	nd due to the car d at the time, da	use(s) and ma te and place,	anner as si and due to	tated. the cause(s)
	To the Hospitel or A within 24 hours after To the Funaral Dirac completely filled in by	Me	29b. Signature and title of certifier	101.			290	License	number	~ .	29	d. Date signe	d (Month.	Day, Year)
			>	(Mesz	~ N	9		D	217	16	5	WYE	MAG	21,2005
	1		30. Name and address of person with the control of	no completed cause of	death (Item 23a	a) (Type,	Print)	TCH	100 1	HW	y las.	AUGA	JA	MD
7	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 2	32. Regist	rar's Signature	P	parke	,						

		1	For Amend Items 23	State of Marylar 1,25 per ME,	nd / Depa G847_09	riment of H	lealth and Death	Mental Hyg	giene Reg. No. O. O. O. O.	
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th 2005	3 Zimelof Death
	Physicia /Medic		David Dengro					July	Z7 ZUN	- 11:10 AM
}	Examin		4a. Facility Name (If not institution, give str	eet and number)	,	4b. City, Town, or	Location of Dea	th	4c. County of Dea	th
			Johns Hopkins B	Kyview Med	in Center	Baltom	one,	MD.	Bulhinou	e City
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day		thplace (State or Foreign ountry)
	Director		220-20-5846 Usual Residence of Decedent	/	6 113.			3/21	11929	MD
	land ow		10a. State 10b. County	10c. Ci	ity, Town or Loc	ation				10d. Inside City Limits
	Mary -f sh	to	MD N/A]	Baltimo	re				1X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	th witi	ai D	1434 Broening High	vay		212	24		USA	
	hours after death with the Maryland turat; or items 23a or 28a-f show at Exactiner must be notified at	Funeral	11. Marital Status	. Was Decedent Ever in L Armed Forces?		Vas Decedent of H Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
36	or it	by Fu	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 X No If Yes, Give	1	☐ Yes 2🌠 No	Specify:		Specify: Whi	to
Ö	J within 72 hours after death with the Marylan jiene, than "natural", or tiems 23a or 28a-1 show the Medical Examinar must be notified at	Q D	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	Year or Dates:	16a Deced	ent's Usual Occup	ation		16b. Kind of Business	
15	within 72 ene. than "nai	Completed	(Specify only highest grade	completed)	(Give	kind of work done	during most of w	orking	TOD. THIS OF BUSINESS	modelly
212	i filed withir Hygiene. other than	mo	Elementary/Secondary (0-12) 9 vears	College (1-4or 5+)	Mil	kman			Delivery	
פַ	H H	Be C	17. Father's Name (First, Middle, Last)					ame (First, Middle,		
/lar	5 9 2 5 7	ToE	Benjamin Denaro				Christ	ina Gent	ile	
Maryland 21215-0036	2 sh and ls m		19a. Informant's Name/Relationship (Type	•		•			r, City or Town, State,	
	s 1 and f Health item 27 other tr		Elizabeth Denaro	wife	Place of Dispos		Highway	Date Date	ore, MD. 2	
lore	Pages 1 nent of F int: if ite iry or ot		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re	moval from State	cemetery, cren	natory or other plac			′	
Baltimore,	rtmer rtant njury	1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 			Faith Cemed		- - - - - 	Rosedale,	
Ba	permit. Pages Department of i Important: if ite any injury or o		Ehithony C	Conne	X VU 7	110 Soll	ers Poir	nt Road, 1	Dundalk,P. <i>B</i> Dundalk,MD.	21222
			23a. Part 1. Enter the disease or complic shock, or heart failure. List only one	ations that caused the dea	th. Do not ente	er the mode of dyin	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cerebror			dent/	-	Menistion	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	,		/	7/	77
	Ladillilei	<u>.</u>	Sequentially list conditions, b.	Du- to (or as a conse	quence of):	Tron	\cap	1//	1	
	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	243 10 (0. 40 4 00.00	4401100 017.			JED BY MEDICAL SAN	ALL THE PERSON NAMED IN COLUMN TO PERSON NAM	
Ć,	The law requires that the death certificate be executed to be as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):		APPRO	VED BY MED.		
8760,	le be ysicia e bur	dical	d.			CERT	IFICATION			
9	tificat ng ph) as th	ledi	N= == 1							
Вох	eath certific attending p	an/N	23b. was decedent pregnant	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	1		23d. Date of de	livery Day Year
	e dea the at ned fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5□	Other (specify) _			Works	Day
P.0	res that the de signed by the a be detached		Part II. Other significant conditions cont	ributing to death but not re	sulting in the ur	derlying cause giv	en in Part I	23e. Did to	obacco use contribute t	the cause of death?
S,	signe d be d	l by	S. L. C. L. L.	SIP PI	11 - 15 - 15 - 15 - 15 - 15 - 15 - 15 -		// .			robably 4 Unknown
Records,	w require been si should t	Completed	10000	7			7	24a. Was	an 24h Ware a	utopsy findings available
Rec	has ge 2	id III						autop perfor	sy prior to death?	completion of cause of
a		e Co	25. Was case referred to medical				OS Plans of D	1 ☐ Yes eath (Check only o		2 No
Vital		o Be	examiner?	spital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	00		lence 6 □Other (Spe	ecify)
of	Physer this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injur	y at		now injury occurred	
ion	Attending I r death. sctor; After by the funer	atio	1 Natural 5 ☐ Pending investigation	(Month, Day 1 Gal)	injury		Yes 2 □ No			
Division	r Atte ter de fracto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
۵	oitaí o urs aft rei Di							1		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physical Exemin	cien: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the tit restigation, in my o	me, date and pla ppinion, death oc	ce, and due to the c curred at the time, c	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	1		29c. Licens	e number 5	HH#	29d. Date signed (Mon	th, Day, Year)
•			reffry m. 7	low M.D		Ke	1001-	T4805	11/22/	05
	(5)		30. Name and address of person who cor						,	
	~		31. Date filed (Month, Day, Year)	July 32. Registrar's Sign	Hoph.	V 517V	Un Mes	Gint G	enter	
	Sta Regist	ate rar	SEP 0 1 2005	Emple 10 1	Jake					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 31 2005 3:18 A. Frank Dominick DeLuca August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 773 Bridge Drive Pasadena 8. Date of Birth (Month, Day, Year) April 19,1929 Maryland if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1**⊠**M 2□F Yrs 76 Director 220-20-8883 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County ehow. rthen "nature), or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Maryland Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 773 Bridge Drive 21122 U.S.A. death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "ns any injury or other treumatic event, the Media 2006. College (1-4or 5+) Elementary/Secondary (0-12) Anne Arundel County Utilities Inspector 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine Bongionvani Michael Frank DeLuca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 773 Bridge Drive Pasadena, Maryland 21122 Dorothy B. DeLuca_ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Crestlawn Memorial Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-2-2005 Marriottsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service vicenses Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part 1. Enter the disease or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VOI 20 **Physician** /Medical Due to (or as a const Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The law requires that the death certificate be executed physicien and the burial-transit GASTrolA that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical 89 IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ò Month Day Year 4∏Pregnant at time of death 5 Other (specify) signed by the at d be detached to 1 ☐ Yes 2 ☐ No P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown certificete has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after Dire 4 Homicide within 24 hours a To the Funerel L To the Hospitel completely filled 29a. Certifier t 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-060 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) DNES, 622 X 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra 2005

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyd

giene Reg. No.	0	0	5	2	8	7	2	6
Reg. No.					_	•	_	-

•	1 - State Registrar	•	Cer	tificate of l	Death	Re	eg. No. UU5	28/26
ian	Decedent's Name (First, Middle, Last)		DAUTO			2. Date of Deat		3. Time of Death
cal	CLARENCE	W.	DAVIS			August	28 200	5 1220 4
ner	4a. Facility Name (If not institution, give stre				Burwic		4c. County of Dea	
	5. Social Security Number 6. Sex		en fer	GICA If Under 1 Year	If Under 24 Hrs.		mne m	Thplace (State or Forei
		2□ F 5		Months Days	Hours Min.	8. Date of Birth (Month, Day, July 27	,1948 Mai	cyland
	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limi
ğ	Maryland Anne Aru	ndel	Pasade	ena				1 Yes 2 1
Directo	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	ountry?
	749 G Street			2112	22		U.S	.A.
Funeral		Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
Dy L	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		Yes 21 No	Specify:		Specify: W	
	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education	Year or Dates:	163 Doord	lostia Hausi Oscura	ation			
Sec.	(Specify only highest grade co	mpleted)	(Give	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of work I)	ing	16b. Kind of Business	/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 10		uter Sci			U.S. Gove	ernment
υİ	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	Maiden Surname)	
2	Charles Davis				Sara	ıh Ha	rrison	
	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Number,	City or Town, State,	Zip Code)
	Sherry L. Davis	(Wife)	749 0	Street,	Pasadena	, Maryla	ınd 21122	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo		Place of Dispos cemetery, crem	sition (Name of natory or other place	е)	Date 2	20c. Location - City or	Town, State
	*4 □Donation 5 □Other (Specify)		dar Hil	1 Cemeter	ry 09-0	1 - 05 B	Baltimore,	Mary1and
	21. Signature of Funeral Service Licensee	/ /		Name and Addres		1 17	ъ.	
	from St	annu	<u> </u>	Outly For	tyniak fu t Avenue,	Baltimo	me P.A. re, Maryla	and 21230
-	23a. Part1. Enter the disease, or complication hock, or heart failure. List only one complications	ons that caused the dea ause on each line.	th. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Liver	CANO	77				Onset and Death
	resulting in death)	Due to (or as a consec	quence of):					
	Sequentially list conditions, if any, leading to immediate		7)					
	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):					
Examiner	that initiated events c resulting in death) Last	Due to (or as a consec	guence ol):					
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medical	d							
-	IF FEMALE: 23c. 23c.	Il yes, outcome of pregn	ancy _				23d. Date of de	iverv
by Physician	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnancy Other (specify)			Month	Day Year
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	Part II. Other significant conditions contrib	uting to death but not res	sulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
						1 🗆 Yes	s 2.0 X No 3.⊟Pr	obably 4 Unknow
Completed						24a. Was an		itopsy lindings availab
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ט	25. Was case relerred to medical				26. Place of Death			2 No
	examiner? 1 Yes 2 No	ital: 1 XInpatient 2	ER/Outpatient	3□ DOA Othe)C		nce 6 Other (Spe	cifv)
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ci illication.	1 Natural 5 Pending 2 Accident investigation	(, -u),	Injury		res 2 □No			
	3 Suicide 6 Could not be determined 2	8e. Place of Injury - At h building, etc. (Special	ome, larm, stre	et, lactory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
) L								
2	29a. Certifier 1 Certifying Physicia 2 Medical Examiner:	on: To the best of my kno	owledge, death	occurred at the tim	e, date and place,	and due to the car	use(s) and manner as	stated.
Medical	0.10)	and manner stated.					to and place, and dec	
	29b. Signature and title of certifier Transport	7/12		29c. License		- 29	d. Date signed (Monti	
-		4,0		00	47413	' h	rugud Li	8,2005
	30. Name and address of person who complete		m 23a) (Type, F	Print)	- GI	17. ·		
	31. Date liled (Month, Day, Year)	4145 ton 1	TCOL	I CENICA	1914	n DURN	15 1 ms	
e r	·	32 negistrars Signa	M Ana	de				
	SEP 0 2 2005	Bullion A	- Parion					

Registrar DHMH 17 Rev 1/2001

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination of the Incitited at once.

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DAVIS, CIARENCE Baltimore, Maryland 21215-0036

	•	1 - State Registrar	State of Mar	•	artment of H rtificate of I			giene Reg. No. 200	5 28727
X. Discolati		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
Physici /Medic	al	Arelia Victoria D			th Cit. Town or	Location of Dooth	August	23 2005 4c. County of Dea	
Examin	er	4a. Facility Name (If not institution, give s Holy Cross Hospit			Silver	Spring		Montag	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	h year) 9. Bi	rthplace (State or Foreign
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pur *		Usual Residence of Decedent 10a. State 10b. County	1	I0c. City, Town or L	ocation				10d. Inside City Limits
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with the Marylar 3s or 28s-f show	Director	10e. Street and Number 11006 John Paul Jo	nes Avenue		10f. Zip Code 20744			10g. Citizen of What C United Sta	
ire, INIALYIAITU ZIZISOOOO	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Sovorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√√ No	ispanic Origin? (Spe an, Mexican, Puerlo Specify:	acify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
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d be featured by the featured	o Be	Joseph Smith				Sarah Ba	arzell		
shoul nd Me	2	19a. Informant's Name/Relationship (T)	pe, Print)Daught	er 19b. Mai	ling Address (Street	and Number or Rura	al Route Numbe	ar, City or Town, State,	Zip Code)
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ILIMOF it. Pages stment of scient: If it.		4 ☐ Donation 5 ☐ Other (Specify)		Bethel C	-	8/29		Alexandria Mason Fun	
Dattimore, permit. Pages 1 em Deportment of Heali Importent: If item 2 eny injury or other 2005.		21. Signature of Funeral Service Licens	7/ MOI	111 1	661 Good 1	Hope Rd S	E, Wash	ington DC	20020
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a Polyradic),					Approximate Interval Between Onset and Death
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Division of Vital Records, to Attending Physician: The law requires! after death. Director: After this certificate has been signs in by the funeral director, page 2 should be.	Completed by	Parathyroidectomy	Hypertens	sion, acu	te failur	e	24a. Was autor perfo 1 Yes	psy prior to prmed? prior to death'	autopsy findings available ocompletion of cause of second 2X No
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To the Hos within 24 h To the Fun completely	₹ E	29b. Signature and title of certifier				se number Mary	land	29d. Date signed (Mo	nth, Day, Year)
		* Kabut H. L	ucuel Mr)	D0005	5522		August 23,	2005
[0		30. Name and address of person who can Robert H. Gerard	mpleted cause of de MD 1500 Fo:	eath (Item 23a) (Typ rest Glen	e.Print) Rd Silve	r Spring	Marylan	d 20910	
	tate trar	31. Date filed (Month, Day, Year)		r's Signature	12.65				

Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of	Year 1020 PM
Physician //Medical Examiner 4a. Facility Name (If not institution, give street and number) **North** **WEST** AUGUST** 31 2 **AUGUST** 31 2 4b. City, Town, or Location of Death **Puneral Director** August** Year 120PM of Death TIMORE 9. Birthplace (State or Foreign	
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(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	•
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20h Place of Disposition 20h Place of Disposition (Name of	City or Town, State
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22. Name and Address of Facility Staffings Fuller of Address Fuller of Address Fuller of Facility Staffings Fuller of Address Fuller of Facility Staffings Fuller of Fac	21122
23a. Part1. Enter the isease, or complicitions hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filiure. List only only call e on each line.	Approximate Interval Between
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	(Month, Day, Year)
	31 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARP RICHARDSON 5"401 OLD COURT ROAD RANDAUSTUIN MD 21133	2
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	S
State Registrar SEP 0 2 2005 32. Registrar's Signature	

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100	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth Day Year 7:29 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
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Baltimore, M	s 1 and 3 Health itam 27 other tr		John DiAngelo - son 352 North Drive, Severna Park, MD 21146 20a. Method of Disposition 1 \(\text{MBurial 2 \subseteq Cremation 3 \subseteq Removal from State} \) 1 \(\text{Memoval from State} \) 1 \(\text{Monation 5 \subseteq Other (Specify)} \) Meadowridge Mem. Park 8/30/2005 Elkridge, MD	
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge MD 21075	c .
	Pnysician /Medical Examiner	her	23a Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Sequentially list conditions.	
68760,	The law requires that the death certificate be executed the bas been signed by the attending physician and sage 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d	
P.O. Box	at the death certifice by the attending ph tached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Sectopic pr	
	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	
Vital Records,		Be Completed	24a. Was an autopsy findings availab prior to completion of cause of death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	le f
Division of V	ding Phys n. After this funeral di	Certification: To I	1 Yes 2 No	
Div	To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely filled in by the	Medical Certif	29a. Certifier (Check only) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
)	To the within 2 To the complete	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Angust 29 c. License number 29d. Date signed (Month, Day, Year)	
	b Sta		30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Thomas Chari II to No. Aullia, Nd. Baltana MD21228 31. Date filed (Month, Day, Year) SEP 0 2 2005 Acade September 1 September 2 2005	
-	Registr	ar	SEP 0 2 2005 Beauty St Searly	

Physic		1. Decedent's Name Man	e (First, Middle, cilyn	Last)	Lo	uise	Eme	ery	2. Date of Do	3 ^{Day}	2005	3. Time of Death 1:15a M
/Med Exami		4a. Facility Name (//	f not institution,	give street and	number)		4b. City, Town,	or Location of Dea	th	4c. C	County of Deat	th
				Care	Cromwe	ell		kville		F	Baltimor	
Funeral Director		5. Social Security N 043-28-4	1879	6. Sex 1 □ M 2 🖎	7. Age (In	yrs. last birthda Yrs.	y) If Under 1 Year Months Days			th ay, Year) 2-35	9. Birtl Co	hplace (State or Foreign untry) Ct.
land		Usual Residence of 10a. State	10b. County		10	c. City, Town or	Location					10d. Inside City Limits
Mary -f sh	ţō	Md.		NΑ			Baltimore					1 DXYes 2 □ No
n with the 3s or 28e	Funeral Director	10e. Street and Nur 2040 F	_{nber} 'lintshii	ce Rd.	Apt	. 204	10f. Zip Code 2]	L237		10g. Citizo	en of What Co USA	ountry?
is 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examment mines be rediffied at	þ	11. Marital Status 1 Never Marri 3 Widowed		ed 1 🗀 Y	Decedent Ever d Forces? les 2 X No , Give or Dates:	r in U.S.	B. Was Decedent of If Yes, specify Cult		Specify Yes or Norto Rican, etc.)		4. Race - Ame Black, White Specify:	
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filed withi Hygiene. Other than	Be Co	17. Father's Name		4					ıme (First, Middle	, Maiden S	umame)	
should be ind Mental I	To B	Luis				DUARTI	3	Geor	geanna		На	wkins
1 end 2 sho Health and I em 27 Is ma		19a. Informant's Na Kent Ei		ip (Type, Print)	Son		iling Address <i>(Stree</i> 2040 Flint					Zip Code) 21237
Page nent c ant: If ury or		20a. Method of Disp 1 X Burial 2 (* 4 Donation	Cremation	3 □Removal fr ecify)	rom State		position (Name of rematory or other pla ernard's		Date		ation - City or ` Haven	
permit. Pa Departmer Important: any injury once.		21. / ignature of Fu	neral Service L	icensed	1 of	01	22. Name and Addr	· ·			, Md. . Nort	
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		s lock, or hea Imn adiate Cause	rt failure. List c Final	only one cause	on each line.		inter the mode of dy	ing, such as cardia				Approximate Interval Between Onset and Death
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Cillie M. Queen

			ate of Maryland / D	·		ental Hygie	ene	
		1 - State Registrar		Certificate of	Death	Reg	.No.2005	28731
Physicia	an	1. Decedent's Name (First, Middle, Last) Lillie Mae Queer	r Emilo			2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, give street		14.05.7		Augus		
Examin	er	C 11 . 11 .	0 0 1/1		FLocation of Death	•	4c. County of Deat	h
Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs. last bin		If Under 24 Hrs.	8. Date of Birth	N/A	holace (State or Foreign
Director		214-50-4385 1 ¹ M 2	S58	Yrs. Months Days	Hours Min.	(Month, Day, Y		hplace (State or Foreign puntry)
pu »		Usual Residence of Decedent 10a, State 10b, County				reb./,	947 Mary	
ith the Marylar or 28a-f show s rodified at	'n	10a. State 10b. County Maryland N/A	10c. City, Town Balt	imore				10d. Inside City Limits 15√2 Yes 2 ☐ No
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atter death with the Maryla or Items 23a or 28a-f shor	Funerai	11. Marital Status 12. W	as Decedent Ever in U.S.	13. Was Decedent of H		cify Yes or No-	14. Race - Ame	incan Indian.
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"net	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	ng 16	b. Kind of Business/	Industry
within then the Man	duc		ollege (1-4or 5+)		<i>b)</i>	Dr	ivate I	ndu at rv
filed Hygi other	a)	11th grade 17. Father's Name (First, Middle, Last)	I AC	usekeeper	18. Mother's Name			laustry
uld be fental rked tic ev	To B	William H. Queen,	Sr.		Lillie	M. Cla	y	
should be man		19a. Informant's Name/Relationship (Type, Pr	· _	. Mailing Address (Street	and Number or Rura	Route Number, C	City or Town, State, 2	Zip Code)
and 2 ealth n 27		Raymond Queen/ Bro			e Avenue	Baltim	ore,Mar	yland 2121
ges 1 If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Remove	al from State cemeter	Disposition (Name of y, crematory or other place	^(a) 8/26	/05	c. Location - City or	
t. Pag tment tent: jury		`4 Donation 5 ☐ Other (Specify)	Crowns	sville Vet	. Cem.	Cro	wnsville	e, Marylan
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 I manked other then "neturel", cany injury or other treumetic event, the Medical Exergonce.		21. Signature of uneral Service Livensee		22. Name and Addre	^{ss of Facility} Cha terstown	tman-Ha Rd Bal	rris Funtimore,	neral Home Md 21215
-		23a Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death. Do ruse on each line.					Approximate Interval Between
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g Phye ter this neral di	T:u	27. Manner of Death 28a	a. Date of Injury 28b. T	ime of 28c. fnjur	v at 2	8d. Describe how		ay)
endin sath. or: Af	atic	1 Natural 5 Pending 2 Accident investigation	(monn, buy rous)		Yes 2 □ No			
or Att iter de irect	ertification	3 Suicide 6 Could not be determined 286	 Pface of Injury - At home, fabuilding, etc. (Specify) 	m, street, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
pitel ours al	0	On Continue of Continue Division	T-M-1-1					
To the Hospitel or Attending Phywithin 24 hours after death to the Funerell Director. After this completely filled in by the funeral is	edical	(Check only 2 Medical Examiner: O	: To the best of my knowledge on the basis of examination and and manner stated.	dor investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within To the comp	Me	29b. Signature and little of cortifier	0	29c. Licensi	e number	29d.	Date signed (Month	ı, Day, Year)
			MID	RES	-000	A.	19ust 30,	2005
3		30. Name and address of person who complete	ed cause of death (Item 23a) (Tune Driet)	Hospite			
Sta	te		elson, MD	DIVIU	יווין נטדו	CI OF B	e i H vuc	V &
Registr		SEF U 2 2005	32. Registrar's Signature	foods.				

05-5771 B.K.S

MICHAEL ANTHONY ECKLES JR. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25 0 0 5 State Amend Ityem 4c&Unpend Item 23a 27 28a-f per me G847 9-15-05 tas 0 0 5 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Michael Anthony Eckles, Jr. 2005 AUG 11:15A /Medical 4c. County of Death HOWARD 4a. Facility Name (If not institution, give street and number) Examiner 6330 WASHINGTON BLVD. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Nonths Days Hours Min. 5. Social Security Number Unk 6. Sex 8. Date of Birth (Month, Day, Year) Jan. 13, 1976 Birthplace (State or Foreign Country) **Funeral** 1 🛣M 2 🗆 F Director 29 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23s or 28s-f show Exerciper relat be notified at 1 ZYes 2 No N/A Baltimore Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zin Code 3829 Brooklyn Avenue 21225 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White ģ 3 Widowed 4 Divorced 'naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7 th College (1-4or 5+) Laborer General Construction 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Depetiment of Heelth and Mental Hy Important: If Item 27 is marked oth any lighty or other treumatic event size. 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Eckles, Sr. Dorothy Pfeifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Eckles / sister 3829 Brooklyn Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9/3/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 arvas Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List do y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Narcotic intoxication and cocaine use /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien end s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown been si 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 □ No ၉ this 28a. Date of Injury Found th, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Found 11:00 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐No 2 Accident 7-27-05 Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Motel room 28f. Location (Street and Number or Aural Route Number, City or Town, State) 6330 Washington Blvd Elkridge, Md filled in by 4 🗌 Homicide within 24 hours e To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Sighajure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MM AUG. 28, 2005 unime 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11. PENN STREET, BALTIMORE, MARYLAND 21201 MIXIMDIMAD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 2 2005 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		Registrar				Ce	rtifica	te of l	Death		F	Reg. No.	200	5 287
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AUGUST 28, 2005

JOSIE FISHPAW

			Tor State Registrar	State of	Maryland	/ Depa	rtment tificate	of H	ealth a Death	and Me	ental Hy	giene Reg. No	200	5	2873	34
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	Examin	er	2304 Thorn Knoll						shing			100	PG	J		
	Funeral			S. Sex 7	7. Age (In yrs. last	birthday)	If Under	1 Year	If Under:		B. Date of Bir (Month, Da	h Yaari		Birthplace	(State or Fore	ign
	Director		579-56-2362	1 ☐ M 2 ☐ F	65	Yrs.	Months	Days	Hours	Min.	an. 20,	1940	D.0	Country)		
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	ettar d for u	ciar	in the past 12 months?		irth 2 ☐ Fetal de ant at time of deat		Ectopic pre Other (spe						Month	Day	Year	
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DIVISION	Atten r deat octor: y the	flca	3 Suicide 6 Could no	ot be 28e. Place	of Injury - At home	e, farm, str					f. Location (Street an	nd Number or	Rural Ro	ute Number,	_
\leq	s after	Certification:	4 Homicide	buildin	ng, etc. (Specify)						City or To	vn, State	9)			
3	to the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certifying	Physician: To the	best of my knowle	edge, death	occurred a	at the tim	e, date an	d place, an	d due to the	cause(s)) and manner	as stated	d.	
:	the H the Fi	ledical	one)	xaminer: On the ba and mann	er stated.	i and/or in				HI OCCUFFEC	at the time,					
Ì	To	Z	29b. Signature and title of certifier	0			29c.	License	number	17		29d. Da	te signed (Mo	onth, Day,	Year)	
	1		16.77	anacl			1	72,	200	10		<	8/50	190	000	
	5		30. Name and address of person w		e of death (Item 23	3a) (Type,	Print)									
	Sta	ate	31. Date filed (Month, Day, Year)	32 Re	egistrar's Signatur	6										
	Regist		SEP 0 2 2	005	egistrar's Signatur	God										

State of Maryland / Department of Health and Mental Hygien 2005 28735 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2006 Clarence Arch Ferguson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/10/1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Min. Yrs. Director 717-12-2898 89 Virginia Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exertiner must be notified at 1 ☑Yes 2 ☐ No Director MD Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a 638 North Stokes Street USA 21078 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 [X]Yes 2 □ No
If Yes, Give
Year or Dates: 1941-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White Completed by 3 Widowed 4 Divorced "naturel', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) Brakeman Railroad 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic av 2008. ပ Eula Jessee Arch G. Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 N. Stokes St., Havre de Grace, MD 21078 Yoshiko Ferguson- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 08/20/05 Darlington Cemetery Varlington, MD ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, 21. Signature of Funeral Service Licensee MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 110 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has anemia 2 1 ☐ Yes 1 Yes 2 25. Was case reterred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 0 30. Name and agress of perso who completed cause of death (Item 23a) (Type, Print) hesapeorke HYNng 32. Registrar's Signature State 2005 Registrar

		1 _ State	ryland / De	epartment of H	lealth and N	•	_	
		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of I	Death	2. Date of Deat	og. No. 2005	3. 2.8.7.36
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/Medic Examir		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Deat	h
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Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age 1 ☑ M 2 ☐ F 7. Age Usual Residence of Decedent	(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt 1928	thplace (State or Foreign buntry) unk
yland			10c. City, Town o	or Location				10d. Inside City Limits
e Mar la-f st	ctor	MD Montgomery	Silve	r Spring				1 ☐ Yes 2X No
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leath ins 23	erai	901 Arcola Avenue 11. Marital Status 12. Was Decedent Ex	ver in U.S.			pecify Yes or No-	14. Race - Ame	nican Indian,
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in 72 hours an "neturel", o	Completed	15. Decedent's Education (Specify only highest grade completed)		lecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	ation during most of world)	unk unk	16b. Kind of Business/	Industry unit
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r ge je je je je je je je je je je je je je	tion	27. Manner of Death 1 X Natural 5 Pending 2 Accident Accident Accident Service (Month, Day)	Year) Inj	ury Wor	k? Yes 2∐No	200. Describe no	W Injury Cocumbo	
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		30. Name and address of person who completed cause of de	ath (Item 23a) (T	ype, Print)	01.01	Cir	C. na	10 2001-
St	ate	31. Date filed (Month, Day, Year) 32. Registra	150 c	ype. Print) Forest G	IEN ILA	SILVER	SPRINZ I	V 20710
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		-	For State Registrar		Maryland /	Depa		f Health	and M	ental Hy	giene		2873	7
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	Funeral Director		5. Social Security Number 212-42-7736 Usual Residence of Decedent	6. Sex 1 M 2 □ F	Age (In yrs. last)	birthday) Yrs.		ear If Under	Min.	8. Date of Birl (Month, Da Jan. 1	y Year)	l Co	hplace (State or Foreign untry) LYLand	_
	a-f ahow	ctor	10a. State 10b. County Maryland Balta		10c. City, To		ocation timore						10d. Inside City Limits 1 ☐ Yes 2 1 No	
	th with the 23a or 28	Funeral Director	10e. Street and Number 4325 Hallfield	l Manor Driv	1e		10f. Zip Cod	236			10g. Citi:	zen of What Co	untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Midical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Mai 3 Widowed 4 Divorced	If Yes Give	es? □ No	1	Was Decedent If Yes, specify 6 1 ☐ Yes 2 🕱			cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify: W	e, etc.	
Maryland 21215-0036	d within 72 ho giene. In then "netul	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12th Grade	nt's Education st grade completed) College (1-4		(Give life.	dent's Usual Oi kind of work di DO NOT use re	one durina mo	st of workin	ng	Sel	nd of Business 26-Empl 26er	•	
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	and 2 sho alth and h 27 le me er traume		19a. Informant's Name/Relation Mrs. Lenore Ge									Town, State, 2 MOTE, 1	Zip Code) MD 21236	
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8760, •	cate be executed physician and the burial-transit	icai	resulting in death) Last	Due to (or	as a consequence	ce of):						J	a dear	
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ORIGINAL

		1 - State Registrar 1. Decedent's Name (First, Middle, Lie					2. Date of Dea	th		3. Time of De
Physic /Medi		Latisha Sharr	on Garner				August	28	2005	7:22
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		University of Mar	~						N/A	
Funeral			Sex 7.Age 1□M 21∏ F	(In yrs. last birthd Yrs	Months Days		8. Date of Birth (Month, Day		Co	hplace (State or F untry)
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yland		10a. State 10b. County		10c. City, Town or	r Location				_	10d, Inside City I
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ath w	la	5440 Jonquil Ave				1215			U.S.A.	
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To the Hospital or , within 24 hours after To the Funerel Dire completely filled in b	Medi	29b. Signature and title of certifier	al Ala			O.C.M.E.		11011	st 30,	2005

State of Maryland / Department of Health and Mental Hygiene 2005 28739 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2.30 A M AUGUST 200 CANDIE JOAN GARBARINO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE APUNEDEC GENBURNIA PSAGIMORE WARHINGTON MEDIZAL CENTRA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-23-1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 49 212-70-2986 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 X No Maryland Pasadena Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other then "natural", or items 23a or or other traumatic event, If a Moulcal Examinar must be 1006 Belgarden Lane 21122 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: Specify: White δ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then na eny injury or other traumatic event, Ite Maulto 2006. Elementary/Secondary (0-12) College (1-4or 5+) 10 years Never Employed Disabled 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Kenneth J. Protani Joan Leaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kenneth Lloyd (son) 184 Lake Shore Drive Pasadena, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 8-31-2005 Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21. Signatur V Funeral J. Wayne Osterling 21122 Part 1 Sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imp - liate Cause (Final Sease or condition esulting in death) 1X1 FARCTION Privisician MOTOCARISIAL /Medical Due to (or as a cons aquence of) Examiner NERPHALORATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of): the attending physicien the desired the burial characters. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 DEctopic pregnancy should be detached for 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 2 No 1 Yes 2 No 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of deriffier 29d. Date signed (Month, Day, Year, 29c. License number o completed cause of death (Item 23a) (Type, Print) Name and a 10.3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2 2005

DHMH 17 Rev 1/2001

Jarbarino

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State of M	laryland /	Depa / Depa	rtment tificate	of H	ealth a Death	ind M	ental Hy	giene Reg. No	200	5	2874	0
Physicia		1. Decedent's Name (First, Middle, Last)	·							2. Date of De August		y 2005°°	ar	3. Time of Death 0204 A.M	ı
/Medica Examine	r r	Tavon Antoine G 4a. Facility Name (If not institution, give s Sinai Hospital	treet and number	7)		4b. City, To Balt			f Death		40	. County of D	eath		_
Funeral Director		213-00-0121	M 2□F 7.A	ge (In yrs. last 20	birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Feb.	v. Year)	9.	Countr	ice (State or Foreig y) yland	7
Maryland f show		Usual Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, To									10	d. Inside City Limits	
with the Na or 28a-		10e. Street and Number 1020 N. Payson S	Street			10f. Zip C	ode 121	7			10g. Cit	tizen of What	Count	y?	
ING 21215-0036 be filed within 72 hours after deeth with the Maryland stal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	-		12. Was Deceden Armed Forces 1 Yes 24 If Yes, Give Year or Dates	s?]No	-	Was Decede f Yes, specif		spanic Origin, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	-	14. Race - A Black, W Specify:	/hite, e		
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Baltimore, Marylar permit. Pages 1 and 2 should be Department of Heelth and Menta important: if Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Seurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place	e of Dispo	sition (Name natory or oth Cem	of per place	9)	D	ate Na				Marylan aryland	
Balti permit. Departm importa any inju		21. Signature of Funeral Service Vice Service	is		5.	240 R	eis	ters	stow	n Rd l	Balt		e,M	ral Hom d 21215	е
Physician	+	23a. Parl 1. Enter the disease, or complied from the complete shock, or heart failure. List only on the complete shock in the comple	cations that cause te cause on each Mull	ed the death. I	-	er the mode					rrest,			Approximate Interval Between Onset and Death	
376(ate be hysicie	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or a	as a consequent	ice of).										
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deta b	<u>۾</u>	Part II. Other significant conditions con	nt inbuting to death	but not resultin	ng in the u	nderlying ca	use give	en in Part I			tobacco Yes 2	_	te to the	e cause of death?	n
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Sta Registr		30. Name and address of person who complete the Volume Mi. Kes. 31. Date filed (Month, Day, Year)	9	strar's Signatur	re	Soule		enn St	treet	t, Balt	imor	re Mary	ylar.	d 21201	

ORIGINAL

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	ninei		ta. Facility Name (If not institution U.S. Route #113	n, give street and num	^{ber)} Southl marker	bound 4b.	City, Town, or I	Location of Dea		4c. Count	by of Death Ester Cou	
Funer Direct			5. Social Security Number Unkn Usual Residence of Decedent	6. Sex 15€ M 2□ F	7. Age (In yrs. last		Inder 1 Year oths Days	Hours Min		9-74	9. Birthplace (S Country) Barbado	
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permit. Pag Depertment Important: I	ā		21. Signature of Funeral Service	K. Was	ters	Ma		H. East	1101 1	E. Nort	, Md. 21 h Ave.	202
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Phy this	Certification: To Bo		S. Was case referred to medical examiner? NOXYes 2 No No. Manner of Death 1 Natural 5 Pendin investing 3 Suiciden 6 Could 1	Hospital: 1 □ Inp 28a. Date of (Month, gation 8-30-0	Injury 28b. Day Year) 5 2:1		DOA Other: 28c. Injury a Work? 1X	4 🗆 Nursing H	28d. Describe h	ence 6XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	k	
To the Hoepitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer			4 Homicide determ	Roadwa g Physician: To the b	est of my knowledg	ne death occu	red at the time	date and place	mile mar	ker, Sn	Route Noute Now Hill,	MD
To the Hoepitel within 24 hours a To the Funerel completely filled	Medical		(Check only one) 2 Medical (Pb. Signature and the discertifie	and manne	is of examination a	ind/or investiga	29c. License r	ion, death occu	rred at the time, d	late and place, 9d. Date signe	and due to the caud (Month, Day, Ye 30, 200	ar)
1/1		3	0. Name and address of person	who completed cause	of death (Item 23a	(Type, Print)	1 Penn	Street	Baltimo	ore, Ma	ryland 21	201
S Regi:	itate strar	3	11. Date filed (Month, Day, Year) SEP 0 2	2005 Reg	istrar's Signature	Sparke	,					

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day ANDREW GROSS DALE /Medical 23 2005 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3309 LYNDALE AVENUE BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□F Director 218-74-5985 42 25 1962 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23e or 28s-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Director XXYes 2 No MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death 3309 LYNDALE AVENUE Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 11☑ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "ne any injury or other traumatic event, the Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 12th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEON BOWEN MARGARET M GROSS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Southern Avenue, Baltimore, Md., 21214 Damon Wm. Bowen/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □Donation 5 □ Other (Specify) MT CARMEL CEMETERY 08-29-05 BALTIMORE, MARYLAND 21. Signature of Sanaral Begins fice 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1 Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) namous **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the contract of the Funeral Director: After the contract of the Funeral Director. physicien and s the burial-transit Due to (or as a consequ Physician/Medical attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: funeral dir Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death.

Director: Afi 1 ☐Yes 2 ☐No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Delli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature 29d. Date signed (Month, Day, Year) 8/26/0521201 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene 28743 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30, Bernice Η. Gutheim 2005 12:10 PM August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

7. Age (In yrs. last birthday)

Rockville

Montgomery

Physician /Medical Examiner

Brighton Gardens

5. Social Security Number

Funeral Director

the Maryland r then "natural", or items 23a or 28s-f ehow the Medical Examiner must be notified at filed within 72 hours after death other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other treumatic event 2008.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Pnysician /Medical Examiner

physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed guipt atten for u ed by the a detached f s been signed t certificate After th I Director: A sd in by the f death filled in by within 24 hours effer a To the Funstsi Direct completely filled in by To the P D 3

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 21, 19) 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F 92 Yrs. 213-38-4560 1913 South Dakota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5210 Goddard Road 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George L. Howard Daisy McCauley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George C. Gutheim / Son 301 E. Paseo Churea, Green Valley, Arizona 85614 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) September 1, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. ette M01305 inne 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Systolic Dysfunction, Chronic Obstructive Pulmonary 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Disease, Renal Failure, Dementia, Cor Pulmonale, 24a. Was an autopsy performed? Malnutrition 1 Yes 1 Yes 2∏ No 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA ဥ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier thyan sundar D53367 August 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, Suite 202, Gaithersburg, MD 20878 Shyamsundar Rajan, M.D.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month Er) Year) 2

32. Registrar's Signatu

2005

		partment of Health and Mental Hy ertificate of Death	Reg. No. 2005 28741
Physician /Medical Examiner	Marjorie B. Glomb 4a. Facility Name (If not institution, give street and number) 7813 Fulbright Court	Month	2039 M 4c. County of Death Mont gomery
Funeral Director	5. Social Security Number 480-01-1025 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) 90 Yrs.	Months Days Hours Min. (Month, E	irth 9. Birthplace (State or Foreign
item 27 is marked other than "natural", or itsms 23s or 28s-1 show other traumatic avant, the Medical Evaninar must be notified at To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or to Maryland Montgomery Bethesda 10e. Street and Number 7813 Fulbright Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No 1 Yes 2 ☒ No 1 Yes 2 ☒ No 1 Yes 7 ☐ Yes		Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home e, Maiden Sumame) kins ber, City or Town, State, Zip Code)
Important: if itam 2 any injury or other once.	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition Crematory of Montgome Crematory 21. Signature Numeral Service Licensee	position (Name of smattery or other place) LTY LTY LTUM, Inc. 2, 2005 22. Name and Address of Facility Robert A ethesda-Chevy Chase, Incethesda, Maryland 20814. There the mode of dying, such as cardiac or respiratory	Bethesda, Maryland Pumphrey Funeral Home, 7557 Wisconsin Avenue arrest, Approximate Interval Between Onset and Death
the burial-transit applications and a second a second and a second and a second and a second and a second and	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	y LTC Beukemia	2 Years
be deteched for use as t by Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
should eted	Part II. Other significant conditions contributing to death but not resulting in the Cachexia Chronic Obstructive Pulmonary Diseas	1	tobacco use contribute to the cause of death? Yes 2\(\subseteq \text{No} \) 3 \(\supseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \) s an \(24b. \text{ Were autopsy findings available} \)
actor, page 2	Congestive Heart Failure 25. Was case referred to medical	auto	prior to completion of cause of death? 2X No 1 Yes 2 No
ed in by the funeral direc Certification: To E	examiner? LX Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death LX Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ont 3 DOA Other: 4 Nursing Home 5 🖔 Res of 28c. Injury at Work? M 1 Yes 2 No	
	4 Homicide determined 289. Place of injury - At home, farm, s building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge dea	th occurred at the time, date and place, and due to the	(Street and Number or Rural Route Number, swn, State)
To the Fune completely fil Medical	(Check only 2 Medical Examiner: On the basis of examination and/or is and manner stated. 29b. Signature and title of certifier	nvestigation, in my opinion, death occurred at the time 29c. License number	date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
06	30. Name and address of person who completed cause of death (Item 23a) (Type	0101235236	September 1, 2005
State Registrar	Ruben Acosta, M.D. NNMC, 8901 Wisc 31. Date filed (Month, Day, Year) 32. Registrar's Signature	consin Avenue, Bethesda,	Maryland 20889

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland		artment of He <i>tificate of D</i>			ne no.2005	28745
	Physic	ian	1. Decedent's Name (First, Middle, La	H. Harton	,			2. Date of Death	Day 2005	3. Time of Death
	/Medi Examir		Je Der t 4a. Facility Name (If not institution, giv			4b. City, Town, or Le	ocation of Death		4c. County of Deatl	1400 PM
1	Zami		611 WATER WHEEL I			MILLERSVII			ANNE ARU	
	Funeral Director		5. Social Security Number 6. S 2.1.2 -46-5025 Usual Residence of Decedent	7. Age (In yrs. last	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye OCT, 13	9. Birth Co.	nplace (State or Foreign unity)
	72 hours alter death with the Maryland naturel; or items 23e or 28e-1 show lical Examinant nate or cities at	Funeral Director	10a. State 10b. County ANNE 10e. Street and Number,	Arundel M	Town or Lo	cation LESVIIIC 10f. Zip Code		100	Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
	23 o	a D	411 Wake	Wheel LNI	9st. 14	2110	8	199.	U.S.A.	andy;
21215-0036	72 hours after dea nature!', or items ilgal Examination	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amos Forces? 1 Dyes 2 No If Yes, Give Year or Dates:	13. V	Vas Decedent of Hisp Yes, specify Cuban,	anic Ongin? (Sp Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
15-	in 72 h	lete	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Deced	ent's Usual Occupation kind of work done during ONOT use retired)	on ing most of work	ing 16b	. Kind of Business/li	,
212	be filed within 72 ho ital Hygiene. id other then "natur event, it e Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1110.	1. 61	d		Disable	ed
	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)	, ,		18		e (First, Middle, Maid	- 1	
Maryland		2	19a. Informant's Name/Relationship	y Harton				e Ellen		
	ges 1 and 2 should it of Health and Mer iff item 27 is marke or other traumatic		Dorothy Lato z	77 - 1	19b. Mailing	Address (Street and	1 A		y or Town, State, Zi	p Code)
ore,	ges 1 and 2 of Health If item 27 in		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	20b. Plac	e of Dispos	ition (Name of atory or other place)		vue, Bal Date / 20c.	Location - City or T	Own, State
Baltimore,	thent of I tant: If it		4 □Donation 5 □ Other (Specify) Breeze	VHOUN	It Cremato	ey 9/5	1/05 3	Utimore,	md
Bal	permit. Page Depertment of important: in any injury or		21. Signature of Funeral Service Licer	-tule	-1	Name and Address of Bradley - 2134 W.	Ashton	Dring KO	Home,	P.A.
			23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final	orie cause on each line.						Approximate Interval Between
	Physician /Medical		disease or condition resulting in death)	a. Hype Achsive (and	orascular	r disea	se		Onset and Death
	Examiner		Sequentially list conditions	b	ice oi).					
	ed isit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):					
<u>,</u>	execut n and ial-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequen	nce of):					
09289	tificate be executed g physicien and as the burial-transit	edical	(d						
			IF FEMALE:							
P.O. Box	The law requires thet the death cer ste has been signed by the ettendir page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 E	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
S, D	igned be deta	by P	Part II. Other significant conditions or		ng in the und	derlying cause given in	n Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
ord	w requir been si should l	ted	Cirrhosis of h	ver				1 ☐ Yes	2.26 No 3 ☐ Prob	pably 4 Unknown
Division of Vital Records,	tending Physicien: The law leath. tor: After this certificate has b the funeral director, page 2 st	Completed						24a. Was an autopsy performed?	death?	psy findings available mpletion of cause of 2 \square No
=	Physicien: r this certifica ral director, i	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:		0.1		(Check only one)	37	CCENTE
گ ر	g Phy ter this	n: To	27. Manner of Death	28a. Date of Injury 28	b. Time of	28c. Injury at Work?		ne 5 Residence		, SCENE
Slor	Attending or death.	catlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		2 🗆 No			
Ω	al or Attens s efter deatl il Director: id in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	t, factory, office	2	8f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death o and/or inve	occurred at the time, o stigation, in my opinio	date and place, a on, death occurre	nd due to the cause(ad at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
	with:		29b. Signature and title of certifier	4 0		29c. License nui OCME	mber	29d. D	ate signed (Month, I	Day, Year)
	2		Jashor	tee fuo)			AUG	UST 31,	2005
	1		30. Name and address of person who c	1			DAT TIME	אור או אים פון	ANTO 2120	1
	Stat	~	31. Date filed (Month, Day, Year)	(432) Pagietrarie Cignotura		N STREET,	DALLING	ME, MAKIL	AND, 2120	T
	Registra	ir	SEP 0 2 2005	Acres 15	grown					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August Lawrence Harvey 30 Μ. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Riverview Nursing Center Essex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) March15,1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Months Days Hours 1**∑**M 2□F 219-05-7668 84 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Marylend 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "natural", or iteme 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at MD Baltimore 1 ☐ Yes 21X No Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809-A Briar Hill Place 21221 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □XYes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3€3€Vidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should ba filed within Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then ' College (1-4or 5+) Railroad Elementary/Secondary (0-12) Conductor 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown Florence Michaels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Larrian Harzarik /daughter 40 Wiltshire Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 8/31/05 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD Bayview Crematory ' 4 □ Donation 5 □ Other (Specify) injury 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex noy in 300 Mace Ave. Baltimore MD 21221 ications that caused the de me ne cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or shock, or heart failure. List only Approximate Interval Between Onset and Death Suspe de Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclen Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached a∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be blashic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ H0 24a. Was an has page 2 autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident ofter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 To the 29b. Signature and title of certifier BASTERN BLUD-MD-2/22/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NASERM. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Nancy Hudak 05-05711 NJM

Unpend item#23a,27,28a-f,perME, 10-21-05-Hre All Copies Are Legible.

			1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and Natificate of Death	Mental Hygier	ZUUJ ZNIU
			1. Decedent's Name (First, Middle, La	st)		2. Date of Death	3. Time of Death
	Physici /Medi		Nancy	Hudak		August	23 2005 1722 ^M
	Examir		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Franklin Square	Hospital	Rosedale		Baltimore
2	Funeral Director			7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthplace (State or Foreign Country)
9	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	/	10d. Inside City Limits
	/anyl	ō			7 1 1 1 1 1		1 Yes 2 No
	158-	Director	10e. Street and Number	rore Dune	10f. Zip Code	100	Citizen of What Country?
	3a ol	<u>=</u>	2509 Amble	o Rd	21222		USA
	deat	ner	11. Marital Status		Was Decedent of Hispanic Origin? (Sc	pecify Yes or No-	14. Race - American Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If item 27 is marked other then "netural", or items 23a or 28s-1 show or other treumatic event, it a Medical Examinar must be notified at	Completed by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	o Hican, etc.)	Black, White, etc. Specify: WK; K
ğ	2 ho	ted	15. Decedent's E		edent's Usual Occupation	16b	. Kind of Business/Industry
215	thin 7	ple	(Specify only highest gra Elementary/Secondary (0-12)		e kind of work done during most of work DO NOT use retired)	king	
	filed wil Hygien other th	Con	8		Home maker		OWN HOME
nd	d oth	Be	17. Father's Name (First, Middle, Last		18. Mother's Nam	ne (First, Middle, Maid	den Sumame)
yla	should ind Men marke umatic	으	Michael Evan		Mary	1 UNKNO	
Maryland	12 sh h and 7 ie m		19a. Informant's Name/Relationship (ing Address (Street and Number or Rul	ral Route Number, Cit	ty or Town, State, Zip Code)
-	1 and Heelth em 27 ther tr		20a. Method of Disposition	K - Hushard 2500 20b. Place of Disp	osition (Name of	DUNOUK Date 20d	Location - City or Town, State
Por	nt of rt of r or o		1 Burial 2 Cremation 3	Removal from State cemetery, cre	ematory or other place)	~ / = 100.	Decation - City of Town, State
Baltimore,	permit. Peges 1 and 2 Department of Heelth s Important: if item 27 is eny injury or other tre <u>pnca</u> .		4 ☐Donation 5 ☐ Other (Special 21. Signature of Funeral Service sice		Russian Orthodox 8/2 2 Name and Address of Facility	7/05 7	Saltmore, MD
Ba	Depertr Imports eny inje) & reter S.	Dolla 2	Bradley - Ash to	N FUNERO	21222 P.A.
			shock, or heart failure. List only	plications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Complications of	Myocardial Perfora	ation	Onset and Death
	Examiner			Due to (or as a consequence of):			
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	en and rial-trar	Exa	resulting in death) Last	Due to (or as a consequence of):			
8760,	icate be executed physicien and s the burial-transit	dicai	•	d			
9	artifice ing ph e as t	Med	IF FEMALE:				
Box	eath certific ettending p	lan/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delivery Month Day Year
_	The law requires thet the death certificate be executed as been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No	4□Pregnant at time of death 5[9□ Unknown	Other (specify)		Month Day Year
P.O.	res that the de igned by the be detached		Part II. Other significant conditions of	contributing to death but not resulting in the u	undertying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Records,	urres sign	d by				1 ☐ Yes	2 No 3 Probably 4 Unknown
00	w require been si should I	Completed				24a. Was an	24b. Were autopsy findings available
	he lav	E C				autopsy performed	prior to completion of cause of death?
ta	en: T tificet tor, p	0	25. Was case referred to medical		26 Place of Dear	1 X Yes 2 ☐ I th (Check only one)	No 1 ☐ Yes 2 ☑ No
of Vital	Phyaiclen: this certifier ral director, I	To B	examiner? 1 ∰ Yes 2 ☐ No	Hospital:	Other		6 ☐Other (Specify)
ō	og Ph ter th		27. Manner of Death	28a. Cate of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in	niury occurred
Division	death. ctor: Afr	Certification:	1 □Natural 5 □ Pending 2 X Accident investigatio	August 23.05 5:20	1074 001-	Catheter P	Injury during
Νį	r Atte	‡	3 Suicide 6 Could not be determined	e con Diagonal Lainer At Lainer			and Number or Rural Route Number, ate) Franklin Square
Q	its eff			Scene			Baltimore, MD
	To the Hospitel or Attending Physicien: The i within 24 hours efter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ▼ Medical Examone)	nysician: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, avestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
			I from to Fres	thall MA	OCME	A	gust, 24, 2005
				completed cause of death (Item 23a) (Type,		110	-3,,
			famela E. Sou			t Baltimo	ore, Maryland 21201
	Sta Registr		31. Cate filed (Month, Day, Year)	32. Registrar's Signature			

se 7	Type or Print in Black Indelible Ink. Ensure A	II Copies A	re Leg	jible.							
	State of Maryland / Department of Health and Mental Hygiene 2005										
	Certificate of Death		J. No.								
Last)	2. Date of Death	Day	V	3. Time of Death						

			For State Ragistrar		State of	Maryl	land / [Depa <i>Cer</i>	rtment tificate	t of H	ealth ar Death	nd Me	ental H	ygien Reg. No		05	28	74
	Physici /Medic		Decedent's Name (First,	Middle, Last)	Willia	m A.	Hammo	ond,	Jr.				2. Date of D Month Augus	Da		Year 005	3. Time of 6:55 A	
	Examir		4a. Fecility Name (If not ins Genesis E				Lane				Location of I	Death		40	County Anne		ınde1	
	Funeral Director		5. Social Security Number 218 03 10	6. Sex	M 2 🗆 F	7. Age (In 92	yrs. last bir	thday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	B. Date of B. (Month, Coept.	irth ay, Year 4, 1	912	9. Birth Cou Mar	place (State on try) yland	or Foreign
	n the Maryland r 28a-f show	Director	Usual Residence of Deced 10a. State 10b. (Maryland 10e. Street and Number	ent County N/A		100	: City, Tow Balt			Code				10g. C	itizen of V	Vhat Cou	10d. Inside Ci 1 X Yes intry?	,
036	be filed within 72 hours after death with the Maryland tal hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	1747 Class 11. Marital Status 1 Never Married 20 3 Widowed 4 Dri	X Married	12. Was Dece Armed For 1 🗷 Yes If Yes, Giv Year or Da	rces? 2 □ No		If	Vas Deced Yes, spec	ify Cuba	ispanic Origin n, Mexican, I Specify:	n? (Spec Puerto R	ify Yes or Nican, etc.)	10-	Blac	e - Amer k, White - Whi		
21215-0036	id within 72 ho giene. er then "netur. . the Medical I	Completed	15. De (Specify only Elementary/Secondary ((not availab	ocedent's Edu highest grade 0-12)	cation e <i>completed)</i> College (1	-4or 5+)		(Give I life. D	ent's Usua kind of wor OONOT us rvisc	rk done d se retired	during most o	of working	9		Kind of Bu		it Pla	ns
Maryland	2 should be filed v and Mental Hygie is marked other raumatic event, th	To Be (17. Father's Name (First, M		am A. H	ammon	d Sr.				18. Mother's	s Name (E mm a	(First, Midd				lable))
	2 = Z :		19a. Informant's Name/Re Song T. Hai								Street						nd 212	230
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 14 ☐ Donation 5 ☐ O	nation 3 DF ther (Specify)		State	ob. Place o cemete Mt. Z:	ry, crem ion	Bapt:	iner pfeð ist	Ch. 8		2005	Тар	paha	nnoc	own, State	
Ba	Depar Impor any ir		21. Signature of Funeral S	re m	oulle	nep	u-	4(001 R	itch	ie Hig	ghway	7 Bal	timo			e, P.A land 2	1225
	Physician /Medical		23a. Part. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	e. List only of	a. Co	CON!	ACC nsequence	() -1	e or dyin	-		e O &				Interval Bet Onset and I	tween
	Examiner	Examiner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events		o. — Dee to (oras a co	TE ary (Hor) (Du	of):										
8760,3	ate be executed hysician and the burial-transit	dicai Exa	resulting in death) Last		Due to (or as a co	nsequence	of):										
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rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant of	conditions co	ntributing to de		et resulting i		, ,	ause giv	en in Part I.			tobacco		ribute to 3 ☐ Pro	the cause of c	death? Unknown
of Vital Record	he law e has b age 2 si	Completed										_	24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. \	death?	opsy findings ompletion of c 2 \square No	available cause of
/ita	ician: T certificat rector, pa	Be (25. Was case referred to examiner?	_	1'4-1						26. Place o	of Death	(Check only	one)				
	Phys ral di	은	1 ☐ Yes 2 No 27. Manner of Death	Pending	1 D l 28a. Date (Mont	npatient of Injury th, Day Yea	2 🗆 ER/Oi 28b. ar)	tpatient Time of Injury	2	8c. Injur Wor	y at k?	28	e 5 🗆 Re 3d. Describe				(y)	
Division	or Attenditer deatlinector:	Certification:	2 Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	investigation Could not be determined	28e. Płace buildi	of Injury - ng, etc. (S	At home, fa	arm, stre	M eet, factory		Yes 2 □ No		3f. Location City or T	(Street a	nd Numb le)	er or Rui	ral Route Num	nber,
_	Hospital or 4 hours afte Funeral Dir ely filled in	ical C			sician: To the													s)

State Registrar

29b. Signaty

SEP 0 2 2005

and title of certifier

ddress of person who completed cause of death (Item 23a) (Type, Print)

OAKWOOD ROAD Glen Burnie, MA 21061

29c. License number

D53462

29d. Date signed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** William Helms 12:30 A.M August 26 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Glen Burnie Anne Arundel Mariner Health Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) May 9, 1927 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1**x** M 2□ F 78 Yrs Virginia 220 24 3187 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location a 23a or 28a-f show 1 ☐ Yes 24 ☐ No Maryland Anna Arundel Glen Burnie Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Ната 23а ог U.S. 1001 Dumbarton Road 21060 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status the Medical Examinent of Black, White, etc. filed within 72 hours after 1 K Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Assembly Operator General Electric 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental P Pages 1 and 2 should be Annie James John Thomas Helms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) partment of Health as sortant: If item 27 is injury or other trace Don Helms / Son 1001 Dumbarton Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition unknown 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Crownsville, Maryland MD. State Veteran Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA ASPIRATION Physician /Medical Due to (or as a consequence of) **Examiner** BRAIN AND LUNG DISEASE METASTATIC Caqueritary not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ funeral director, page 2 should be DRGANIC BRAIN SYNDROME 3 Probably 1 □ Yes 2 □ No 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No death. investigation 2 🖺 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titl of certifier D17753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 710 CHURCH ST. BALTIMORE, MO2120 K.S.DHARMASEMA, M.D. 32. Abgistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

				State of Maryland / Department of Health and	•	iene.	
				1- State Certificate of Death Certificate of Death	R	_{eg. No.} 2 0 0	5 28750
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dear Month	Day Ye	3. Time of Death
		/Media	cal -	John R. Jones 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D.	August	31, 20	05 7:40A M
		Examin	ier	Joseph Richey House Baltimore	eau i	40. County of	Jean
		Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours N	Hrs. 8. Date of Birth (Month, Day, Nov • 3	Year) 9.	Birthplace (State or Foreign Country)
		Director		218-09-5734 XX M 2 F 89 Yrs. Would Residence of Decedent	Nov. 3	1915 1	Marýland
		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		Ba-f s	Director	MD Baltimore Woodlawn			1 □ Yes XXNo
15		with the or 2:	Dire	10e. Street and Number 6508 Gilmore St. 21207	1	0g. Citizen of Wha	
1/0		ns 23	Funeral		? (Specify Yes or No-	U.S.	A • American Indian,
10	9	or Iter	Fun	1 Never Married 2 Married XXVes 2 No	uèrto Rican, etc.)	Black, \	Vhite, etc.
30	21215-003	urel',	d by	XLXWidowed 4 □ Divorced Year or Dates: WWII		Specify:	White
	15-	n "net	plete	15. Decedent's Education (Specify only highest grade completed) [Second of the second	working	16b. Kind of Busin	ess/Industry
SE	212	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or tiems 23a or 28a-f show svent, the Medical End in at most lear chillied at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 Communications T	echnicia	n C&P	Telephone
11	ind	ould be filk Mental Hy arked oth	Be		Name (First, Middle, I		
H	Maryland	d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygjene. 7 Is marked other then "neturel", or Items 23s or 28s-f show treumatic svent, the Medical Exar is wernest be rediffied at	7	James Edward Jones Gertr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	ude Este		
3	Na S	alth ar 27 is or treu		Lois Jones / Daughter 6508 Gilmore St.; W			
	ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from State	Date	20c. Location - City	or Town, State
	Baltimore,	Pag tment tant: I		'4 □Donation 5 □Other (Specify) Lorraine Park Cem.	9/2/05	Wood1a	-
esperil	Bal	permil. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre		21. Signature of Funeral Service kicensee 22. Name and Address of Facility I			
\$				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			Approximate
O. C.		Physician		Immediate Cause (Final disease or condition resulting in death) aa			Interval Between Onset and Death
		/Medical Examiner		resulting in death) Due to (or as a consequence of):	<i>c</i>		years
		Lammer	Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
iB		uted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Einlie Underlying Cause (Disease or injury that mitiated events c.			5.5
, O	oʻ	ate be executed hysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):			
M	8760,	cate be	dlcal	d			
N	9 xo	certifii ding p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
10	B.	death e atter	Physiclan/Med	in the past 12 months? 1 Ves 2 No. 1 Ves 2 No. 1 Ves 2 No.		Month	Day Year
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	ds,	signed d be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death? Probably 4 □Unknown
	COL	w requ	ompleted		24a. Was ar		autopsy findings available
	Re	The la te has	ошр		 autopsy perform 	prior	to completion of cause of h?
	/ital	cien: ertifica ector, p	BeC	examiner?	Death (Check only one		
	of \	Physia this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing	g Home 5 Reside		Specify) TOSPICE
	O	th: After	ıtlon	27. Manner of Death 1. ■ Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) 1 □ Year 28b. Time of Injury 1 □ Yes 2 □ No	28d. Describe no	w injury occurred	
	Division of Vital Records,	r Atter er dea rector by the	Certification;	3 Suicide 6 Could not be determined determined building, etc. (Specify)	28f. Location (Str City or Town	reet and Number o.	r Rural Route Number,
		urs aft urs aft aral Di			4		<u></u>
		To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	edical	29a. Certifier (Check only one) (Check one) (C	ace, and due to the ca ccurred at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
		To th withir To th comp	Me	29b. Signature end title of certifier 29c. License number	29	d. Date signed (M	onth, Day, Year)
	,		2	1 2 Sold D24170		ugust 3	1,2005
		0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. To MD Richer Hooice 838 N EntawSt	Baltimore	MD :	21201
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	.7000.11-001	_	
		Registr	ar	SEP 0 2 2005 May 15 Assets			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Regis	strar		St	ate of	Man	yland /	Cei	artment d <i>tificate</i>	of E	ealth a <i>Death</i>	nd M	ental Hy	gien Reg. N	°20	05	28751
	Physici		1. Decede	ont's Name (I Viola		, Last)	s	•		Ja	acque				2. Date of De Month Augus		ay, 20) 05°	3. Time of Death 2:16 P M
-	/Medic Examin			Name (If no				nber)			4b. City, To			Death		4		of Death	
	Funeral Director		218	Security Num 3-65-3	079	6. Sex 1 ☐ M		7. Age (/	In yrs. last	birthday) Yrs.	If Under 1 \ Months E	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 2–8	ay, Yea	r)	9. Birthp Cour	lace (State or Foreign htry) Liberia
	yland 10w		Usual Res	sidence of Do	ocedent 0b. County			11	Oc. City, To	own or Lo	cation							1	0d. Inside City Limits
	a-f-el	tor	Md		How	ard				Colu	ımbia								1X Yes 2 No
	or 28	Jirec	10e. Stree	and Number	er						10f. Zip Co	ode				10g. C	itizen of	What Cour	ntry?
	ath w 230	ra	655	7 Fri	uit Gi								21045				Liber		
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5-0	72 ho natur	eted		(Specify	5. Decedent	t's Education	n npleted)		10	(Give	dent's Usual C	done di	uring most	of working	ıq	16b.	Kind of B	usiness/Ind	dustry
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	at Hygid I other vent, I	Bec	17. Father	r's Name (Fi	rst, Middle,	Last)							18. Mother	's Name	(First, Middle	, Maide	n Suman	-,	
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altimore,	permit. Pages Department of I Importent: If It eny injury or o		1 CX	Burial 2 0 Donation 5	Cremation		val from S	State	ceme	-	Mem.			9–17-		R	anda	llsto	wn, Mđ.
Ball	permit. Page Department of Importent: If eny injury or once.		21. Signa	iture of Fune	ral Service	Licensee	·	00	nei) 22	Name and A March				Baltii 1101			h A	202 ve.
			23a. Part	11. Enter the ck, or heart f	disease, or ailure. List	complicatio only one ca	ns that cause on ea	aused th	e death. D	o not ent	er the mode o	of dying	, such as o	ardiac or	respiratory a	rrest,			Approximate Interval Between
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isio	death ctor:	licat		Accident Buicide	investig 6 ☐ Could	not be	Be. Place	of Injury	- At home	farm str	eet, factory, o		92 5 11		8f. Location /	Street a	and Numb	er or Rura	i Route Number.
Οį	after after I Direct	Certification:	4 🗆 H	Homicide	determ	iined	buildir	ng, etc. ((Specify)	, , , , , , , , , , , , , , , , , , , ,	oot, rabidity, o				City or To				
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this a completely filled in by the tuneral direction.	Medical C	29a. Cert (Che one	ck only 2		Examiner:		asis of ex	kamination						nd due to the				
	withir To th compl	Me	29b. Sign	ature and titl	le of certifie	r /							number				-	•	Day, Year)
		5	1	lar	det	Hal	lai	LV	ud		C).C.	M.E.			Aug	ust 2	28, 2	005
C	3/		30. Name	and addres	s of person	who comple		e of dear	th (Item 23			ı St	reet.	. Bal	timore	.Ma	rylaı	nd 2	1201
	Sta Regist		31. Date	filed (Month,	Day, Year)		~ ·		s Signature							,	<i>J</i> =		

ORIGINAL

Physici		Decedent's Name (First, Middle, Last) Joann	Е.	patingen o <u>f Heal</u> th and Pertificate of Death Jackson	2. Date of Death Month AUGUST	3. Time of Deat 30, 2005 8:25A.	
/Medic Examin		4a. Facility Name (If not institution, give s FRANKLIN SQUARE HO		4b. City, Town, or Location of De ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director		5. Social Security Number 6. Sex 217-68-0288	M 2X F 7. Age (In yrs. last birtho	Months Davs Hours M	in. 8. Date of Birth (Month Day, Y	9. Birthplace (State or Ford Country) Md.	
e puo	tor	Usual Residence of Decedent 10a. State 10b. County M. d. N. A	10c. City, Town o	r Location Baltimore		10d. Inside City Lin X Yes 2 □	
filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show int, I'na Medical Examinar must be notified at	I Direc	10e. Street and Number 1412 Stawflower	Rd. Apt. E	10f. Zip Code 21221	10g	Citizen of What Country?	
it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f ehow or other treumatic event, the Medical Examinar must be notified at	by Funeral Director			13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
ene. then "natura he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade	cation 16a. D completed) (C College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of v le. DO NOT use retired) Disabled	working 16	b. Kind of Business/Industry N A	
nd Mental Hygi marked other imatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Joseoh	Johnson	18. Mother's N	Name (First, Middle, Ma Viola	_{iden Sumame)} Lightner	
ealth and N n 27 is ma		19a. Informant's Name/Relationship (Ty) Leroy Pittman	Uncle	lailing Address (Street and Number or 310 Charter Oak	Avenue,	Baltimore, Md. 21	
Department of He important: If Iten any injury or oth goose.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State cemetery, King	isposition (Name of crematory or other place) Mem. Pk. 22. Name and Address of Facility March F.H. Eas	-3-05 Baltin	Randallstown, Md. nore, Md. 21202 E. North Ave.	
hysician /Medical xaminer e priial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)				
/ the attending phy: ched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delivery Month Day Year		
has been signed by the ige 2 should be detached	á	Ď	Part II. Other significant conditions con Cocaine use, cirrho				cco use contribute to the cause of death
sete has been page 2 shou	Completed	cardiovascular dis		24a. Was an autopsy performe			
within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	lon: To Be	27. Manner of Death 1 ANatural 5 Pending	ospital: 1 V Inpatient 2 ER/Outp. 28a. Date of Injury (Month, Day Year) 28b. Tim	atient 3 DOA Other: 4 Nursing	Death (Check only one) g Home 5 Residence 28d. Describe how		
s after death al Director: ed in by the t	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examination	sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	or investigation, in my opinion, death or	ocurred at the time, date	and place, and due to the cause(s)	
± 0 E	Σ	29b. Signature and title of certifier	Lee-he- MD	29c. License number	29d	. Date signed (Month, Day, Year)	

28a-f show

items 23a

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and Mental !

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other traumatic event, the Medical Examiner must be notified at

P.O. 1 Records, of Vital

The law requires that the death certificate be executed

Hospital or Attending Physician:

after death.

24 hours a

To the the

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filled in by

the ģ

After this certificate has been si funeral director, page 2 should t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Manyland Department of Health and Mental Hygiene State of Manyland Department of Health and Mental Hygiene Certificate of Death 28753 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Howard F. Kolarik 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Regional Medical Cente If Under 24 Hrs. eninsula WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 218-18-6367 1, 1921 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Worcester Berlin 1 ☐ Yes 3 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Greenwood Lane 21811 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Ho 3 ₩idowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years printer commercial printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony L. Kolarik Elizabeth Kyzour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if item 27 is any injury or other traconce. Ronald A. Kolarik/son 38 Greenwood Lane, Berling, Md. 21811 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ^¹ 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 8/27/2005 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Inc.
21014
Approximate
Interval Between
Onget and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 X No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, axaniner? Other: Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Inetural Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

30. Name and address of



Janet L. Wasson, M.D.

State Registrar

				partment of Health and Me ertificate of Death	ental Hygiene	005 28754
	Physici		1. Decedent's Name (First, Middle, Last) William Patrick Keohan, Jr.		2. Date of Death Month Day	3. Time of Death 2005 1:30 A. M
-es	/Medic Examin		4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home	4b. City, Town, or Location of Death Charlotte Hall	4c. C	County of Death Mary's County
Ì	Funeral Director		5. Social Security Number 016-12-4188 6. Sex 7. Age (In yrs. last birthday 84 Yrs.	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) lay 14,1921	9. Birthplace (State or Foreign Country) Boston, MA.
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Baltimore County Towson	ocation		10d. Inside City Limits 1 ☐ Yes 2♥ No
	or 28a-	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citize	en of What Country?
	ath wi	ral	8328 Carrbridge Circle	21204		ted States
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. If it is marked other then "naturel", or items 23e or 28e-f show If item 27 is marked other then "naturel", or items 23e or 28e-f show of items 21e marting the rotified at or other treumatic event, the Medical Evantral must be rotified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amped Forces? 1 Zives 2 No If Yes, Give W.W.II	. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric		4. Race - American Indian, Black, White, etc. Specify: White
0-612	ithin 72 ho ne. nen "natur Medicel	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)		d of Business/Industry
7 7	iled w Hygier ther th		17. Father's Name (First, Middle, Last)	Insurance Salesman	First, Middle, Maiden S	Insurance
ylalıc	ould be f I Mental H narked of natic ever	To Be	William Patrick Keohan, Sr.	Helen McDe	rmott	
Z	and 2 sh eaith and m 27 ie m ner treum			ling Address (Street and Number or Rural F 328 Carrbridge Circl		Town, State, Zip Code) Maryland 21204
ע	Pages 1 and 3 nent of Health out: If item 27 ary or other tre		20a. Method of Disposition 20b. Place of Disposition cemetery, cre		te 20c. Loca	ation - City or Town, State est Hill, Maryland
Dalimino	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensea Jeffrey L. Gair, Sr	32. Name and Address of Facility eaceful Alternative	s Funeral&0	Cremation Ctr.,P.A.
			23a. Part I Enter the disease, or complications that caused the death. Do not en shack, or heart failure. List only one cause on each line.	JOES TOTA ROAD TIMO	TITUMITE Y TO	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CEREBRO VAS C Due to (or as a consequence of):			Interval Between Onset and Death
	Examiner					
,0070	cate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
O. BOX 60	ath certific attending p for use as	Physiclan/Med		□Ectopic pregnancy □ Other (specify)	23	ld. Date of delivery Month Day Year
בי לפונים	v requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the CHRONIC OBSTRUCTIVE PULMONARY	underlying cause given in Part I. Y DISTASE, DEMENTIA		e contribute to the cause of death?
ממפנים	he law requir e has been si ige 2 should i	Completed		USLON, HYPERTENSION	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
VII	sician: The lav certificate has rector, page 2	o Be Co	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C		1 ☐ Yes 2 No
VISION OF	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2	H .	1 Yes 2 Mo 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 28c	e 5 ☐ Residence 6 [d. Describe how injury o	
	al or Atte s efter dea I Directo d in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f	f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the cause(s) are at the time, date and p	nd manner as stated. Jace, and due to the cause(s)
	To ti To ti comp	×	29b. Gigneture and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)
, ((~		pelpres publica	D 50963	0	8/31/2005
در	(1/2		30. Name and address of person who completed cause of death (Item 23a) (Type FULTON LUH3JN M.D.,	HVH. CHARLOTTE	E HALL,	MD 20622
	Sta Registr		31. Date filed (Month, DaySPP) 0 2 2003 Register's Signature	Sperke		

			1- For State of Maryland / Department of Health and Mealth ntal Hygier	2005	28755	
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		PAUL HENRY KNICKMAN		25 2005	12364
ed!	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BAIFO. WASh. Med. Center GRN BURN	ie	4c. County of Death	
H	Funeral Director		215-40-4166 X Y 2 63 Y S.	8. Date of Birth (Month, Day, Ye Feb 17,		ce (State or Foreign y) unk
	and w	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		100	d. Inside City Limits
	Maryi -f sho	টু	MD Anne Arundel Pasadena			1 ☐ Yes 2√ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Countr	y?
	th wit	ai D	8188 Riverside Drive 21122		USA	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or Items 23e or 28e-f show other traumatic evant, the Medical Evantinal must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Sperify Sperify Cuban, Mexican, Puerro Fundamental Status) 13. Was Decedent of Hispanic Origin? (Sperify Sperify Sperify Cuban, Mexican, Puerro Fundamental Status) 14. Was Decedent Ever in U.S. Armed Forcas? 15. Was Decedent of Hispanic Origin? (Sperify Sperify	cify Yes or No- Rican, etc.)	14. Race - America Black, White, et	c.
Ş	2 hou	ed	15. Decedent's Education 16a. Decedent's Usual Occupation	unk 16b	. Kind of Business/Indu	istry unle
215	hin 73	pie	Floreston/Secondary (0.12) College (1.4or.E.) life. DO NOT use retired)	_		
2	filed wit Hygiene other the	Completed	unk 2 Mectronic lechnician		omputer	1
and	ould be fill Mental Hy sarked oth	Be	17. Father's Name (First, Middle, Last) Harry Knickman 18. Mother's Name Bernadett	(First, Middle, Maid e Sauern		-unk-
눈	2 should and Men is marke eumatic	To	19a Informant's Name/Relationship (Type, Print). Denise Knickman/Daughter Baltimore Washington Med Ctr 301 Hospital Drive Glen			ode)
	1 and 2 Health am 27 ther tre				MD ZFOGY Location - City or Tow	
altimore,	Pages nent of I int: If its iry or o		1 图 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 图 Other (Specify) in State 1 □ Donation 5 图 Other (Specify) in State		lto. Md.	.,
Balti	permit. Pages Department of Important: If it any injury or o		21. Six ature of Funeral S. ice Licensee 22. Name in Landing Board State Anatomy Board Baltimore, MD 21201		e 6415 Bel/ Md. 21206	lir Rd.
6	hysician /Medical Examiner		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock for heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	r respiratory arrest,	<u> </u>	Approximate nterval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, in any leading to find office cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
.O. Box 68	ath certif ttending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliven Month E	√ Day Year
ds, P	uires that the de n signed by the a ld be detached f	d by Pf	Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
	The law requir ate has been si page 2 should l	Completed		24a. Was an autopsy performed 1 Yes 2	? prior to com	sy findings available pletion of cause of
ita Ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?	(Check only one)		
5	physic this c	2			6 Other (Specify)	
u C	ding F	ioi	1 Novatural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how in	njury occurred	
Divisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident	28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	edical Co	29a. Certifier (Check only (Check only 2) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred			
	thin 2 thin 2 tha mplet	Med	29b. Signature and title of certifier 29c. License number		Date signed (Month, D.	ay, Year)
)	Z Z Z S		Milli Para no Donness	4	8/26/2	-
			30. Name and address of person who completed care of death (Item 23a) (Type, Print)		-113	
			al Der fled (Moth Day York) 30 Resistants Singular	A 21	035	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

		1	For State Registrar	State of Maryland		rtment of H		Reg.	ne 2005	28756
Ī	Physicia /Medic	n al	Decedent's Name (First, Middle, Last) GELAUD A. Facility Name (If not institution, give s	INE	KEP	ZIERSK 4b. City, Town, or		AU6UST	Day Year 26 2005 4c. County of Death	3. Time of Death 12 50 A M
	Examin Funeral Director		5. Social Security Number 6. Sex	EST HOJPI		PAN If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		ar) 9. Birth	
Marylan	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I're Marical Examities is until the notified at	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade	12. Was Decedent Ever in U. Armed Forces? 1	16a. Deced (Give life. L disat	Stown 10f. Zip Code 21 Vas Decedent of Hi Yes, specify Cuba □ Yes 2 No lent's Usual Occuping Kind of work done of the coop NOT use retired of the coop of the	specify: ation furing most of wor 18. Mother's Nam Ruth	pecify Yes or No- o Rican, etc.) In the second of the sec	Citizen of What Cou USA 14. Race - Ameri Black, White Specify: white b. Kind of Business/In none den Surname) ity or Town, State, Zi MD 21224	can Indian, etc. t e ndustry
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 ☒ Other (Specify) 21. Signature of Funeral Service Licens	nemoval from State in state and stat	emetery, crem	ltimore,	ss of Facility Omy Boar MD 212	d 655 W. B		
,092	Medical Examiner The burnal-transit	ical Examiner	shock, & heart failure. List only of timmediate Caulse (Final disease or condition resulting in death)	a. ATHELD SCL Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	eco 77 uence of): uence of):					Interval Between Onset and Death
.O. Box 68	death certific e attending p od for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3[Ectopic pregnancy Other (specify)	1		23d. Date of deliment	Day Year
Vital Records, P	e law requires has been sign ge 2 should be	Completed by P	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		prior to death?	obably 4 Nunknown topsy findings available ompletion of cause of
Division of Vital	nr Attanding Physician: for death. iractor: After this certific h by the funeral director,	Certification; To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man er of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)		f 28c. Injur Wor M 1	er: 4 □ Nursing I	ath (Check only one) Home 5 Residence 28d. Describe how 28f. Location (Street City or Town, 5	injury occurred	
)	To the Hospitel of within 24 hours of To the Funerel D completely filled in	Medical Ce	(Check only 2 Medical Examone) 29b. Signature and title of certifie	ysician: To the best of my kno niner: On the basis of examina and manner stated	MD	29c. Licens	ppinion, death occ	urred at the time, date	se(s) and manner as a and place, and due Date signed (Month	to the cause(s)
ı	St Regist	ate rar	30. Name and address of person who of MUNEL ROTYKIN 31. Date filed (Month, Day, Year) SEP 0 2	completed cause of death (tter 590 000 00 32. Registrar's Signa 2005	INT RI	UASI CAN	MUSTO	on mary	WD 2	-1117

		•	1- State of Maryland / Department of Health and Certificate of Death	Mental Hygie	ene 2005	28757
Ť	Physici	an	1. Decedent's Name (First, Middle, Last) CHARLOTTE THELMA KEATLEY	2. Date of Death		3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea Harbor Hospital Center Baltimor	ath V	4c. County of Deat	3
*	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 7. Age (In yrs. last birthday) 1 F Under 1 Year Months Days Hours Mir		9. Birt 1927 Ma	hplace (State or Foreign untry) ryland
	show	j.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M s or 28a-f	Direc	Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 51 Thomas Avenue 21225	10g	g. Citizen of What Co	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or Itams 23s. or 28a-f show other traumatic event, the Mudical Examinating the molified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give 1 Year or Dates: 1 Varied 1 Yes 2 No Specify:	(Specify Yes or No- orto Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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Maryland	1 and 2 should I Health and Men tam 27 is marker othar traumatic		19a. Informant's Name/Relationship (Type, Print) Douglas Keatley / son 19b. Mailing Address (Street and Number or F		•	
Baltimore,	Pages 1 and nent of Heiston of Heiston of Heiston or other arry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 4 Name of cemetery, crematory or other place) Holly Hill Cemetery 9/1		oc. Location - City or Baltimore,	
Balti	permit. Page Department o Important: If any injury or once.			Gonce Fune		ce, P.A. yland 21225
8760, 6	Physician /Medical Examiner	dicai Examiner	23a Fart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		it.	Approximate Interval Between Onset and Death 24 hows
Box 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Festal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
rds, P.O.	v requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	
il Records,		Completed		24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of 2 No
of Vital	ding Physician: The h. A. After this certificate funeral director, pag	To Be	examiner? 1 Yes 2 No	eath (Check only one) Home 5 Residen		cify)
Division o	ling After fune	Certification:	27. Manner of Death Statural 5 Pending investigation 3 Suicide 4 Homicide Month Mont	28d. Describe how 28f. Location (Stre City or Town,	et and Number or Ru	ıral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) 13 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one)	curred at the time, date	e and place, and due	to the cause(s)
)	To t withi To tl	×	29b. Signature and title of certifier Minimum Stee, MD RESOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MING HE 30 OI South Hanover Street, 31. Date filed (Month, Day, Year) SEP 0 2 2005	290	d. Date signed (Month	8,2005
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MING ITE 3001 South Hanover Street,	Baltimo	e. Mar	yland 2122
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 2 2005 32. Registrar's Signature			

Paula Rose Kuha 05crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

056	57		1 - State Amend Item 1&	State of Maryla	nd / Depa	artment	of H	ealth a	nd M	lental Hy	giene 5 tas	000	0075
	•		Registrar 1. Decedent's Name (First, Middle, Last)		Ce.	rtificate	of L	Death		2. Date of De		005	28758
	Physic		PAULA ROSE	KUHN						Month	Day 2.1	Year 2005	M
	/Medi Examir		4a. Facility Name (If not institution, give s			4b. City, T	own, or	Location of	of Death	August		ounty of Death	
1			35 Maple Court			E1k	ton					Cecil	
	Funeral		5. Social Security Number 6. Sex	THE OPTICE	. last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da	th ly, Year)	9. Birth Coi	nplace (State or Foreign untry)
	Director		215-74-7264 Usual Residence of Decedent	43	3 115.					NOV. 9	, 1961	L MZ	ARYLAND
	ehow		10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	a-f-th	io	MARYLAND HARFORI	ОСО	EDGEW	OOD							1 ☐ Yes 2XXXNo
	ith the M or 28a-f	Director	10e. Street and Number			10f. Zip (Code				10g. Citize	n of What Co	untry?
	15 w	la	1309 APT 301 GOLI	O MEDAL WAY			210					5.A.	
	items items	Funeral	THE STATE OF THE S	12. Was Decedent Ever in t Armed Forces?	U.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Ori n, Mexican	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Amei Black, White	
9	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		1 ☐ Yes 2	ĭNo	Specify:			S	pecify: WHI	TE
5-0036	72 hours "natural", ologi Ext		15. Decedent's Edu	cation	16a. Dece	dent's Usual	Оссира	ation				of Business/I	
212	c 3	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done di retired)	luring mosi)	t of work	ing			•
1212	filed wit Hygiene ther the	Son	12th grade	,	PICK	ER					PRI	VATE	
פ	華工芸芸	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	e (First, Middle	, Maiden Su	ımame)	
<u>~</u>	should be nd Mental marked o	မ		FLEECE						RES B. I			
Maryland	12 sho h and 7 is m treum	1	19a. Informant's Name/Relationship (Ty	pe, Print)						al Route Numb			ip Code)
-	ss 1 and of Health Item 27		PAUL KUHN/Son 20a. Method of Disposition	20b.	Place of Dispo	sition (Name	e of			ville,		21234 tion - City or 1	Town. State
galtimore,	00		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei	natory or oth	ner place	1	00 0				
	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service License		ERKLEY (9-05			MARYLAND
ä	permit Depertr Importr eny inj		Day law (1.	1	W.	ILLIAM 21 G E	I C I	BROWN	COM	M FUNER	RAL HO	ME-HAR	RFORD, P.A.
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only or	cations that caused the dea								JEIN, ME	Approximate Interval Between
	Pnysician	8 II	mmediate Cause (Final disease or condition	Narcotic i	ntoxica	tion							Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		CION							
	Examiner		Sequentially list conditions.).									
	sit ad	luer	Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or sa s-consc	quanes ot):								
_	and and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
8/60,	icate be executed physicien and the burial-transit	calE			,								
89	ificate g phy. as the			J							1		
Box 6	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Testonia ero					230	d. Date of deli	very
_	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Ectopic pre Other (spe						Month	Day Year
л Э	res that the de signed by the a be detached t	Phy	9 Unknown										
	res th	þ	Part II. Dther significant conditions con	tributing to death but not re	sulting in the u	nderlying ca	use give	n in Part I.					the cause of death?
Records,	w require been sl should l	eted								'	Yes 2 ☐ I	No 3∏Pro	bably 4 Unknown
၌	e taw hes b	Completed								24a. Was		prior to c	topsy findings available ompletion of cause of
	n: Th icate r, pag									12 Yes	2 No	death? 1 Yes	2□ No
1	Physicien: this certificant this certificant all director, and director,	Be C	25. Was case referred to medical examiner?	lospital:	75000		Othe			(Check only o		37	
5	Phy or this oral d	5.	1 ☐XYes 2 ☐ No	28a. Date of Injury	ER/Outpatier 28b. Time of		c. Injury Work	4 □ Nu		me 5 L Resi 28d. Describe			w) at scene
5	Attending or death. ector: After by the fune	atio	1 □ Natural 5 □ Pending 2 □ Accidentinvestigation	8-21-05	10:11	м	Work	? ∕es 2 🛣	No				ulik
DIVISION OF VITAL	Attendi er death. ector: A by the fu	Ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str	eet, factory,	office			28f. Location (Street and f	Number or Rui	le Court
5	rs afte	Cert	7 E Homodo	found in ho						Elkton,	Mary	33 Map 1and	ie Court
	Hospi 4 hou Funer ely fill	cal	(Check only 2 Thedical Examin	sician: To the best of my kn ner: On the basis of examin	nowledge, death	n occurred a	t the time	e, date an	d place, th occurr	and due to the	cause(s) ar	d manner as	stated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Medical Certification;	29b. Signature and title of certifier	and manner stated.				number				signed (Month	
	5 ₹ 6		290. Signature and title of certifier	V. a		250.			177				
			20 Nome and address of	FT & med	2	Deien)	0.	.C.M.	Ŀ.		Augus	t 22,	2005
			30. Name and address of person who co				Stre	eet.	Balt	imore,	Marv1	and 21:	201
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature			,		,			
	Regist	rar	SEP 0 2 2005	the L	k spa	West !							
-													

		-	1 - State of M	laryland / Dep <i>Ce</i>	artment of F ertificate of		Reg.	ne 2005	28759
	Physicia		Decedent's Name (First, Middle, Last) BORIS	K1	RNOS		2. Date of Death Month AUGUST 30	Day 2005 Pear	3. Time of Death 8:40 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number,			Location of Death	1	4c. County of Death	
			302 CANTATA COURT #205	//a last blotheda.) If Under 1 Year	REISTER			TIMORE
	Funeral Director		5. Social Security Number 6. Sex 7. A 1 1 1 M 2 □ F	ge (In yrs. last birthda) 67 Yrs.	Months Days	Hours Min.	8. Date of Birth AUG. 8, 1	938	place (State or Foreign ntry: UKRAINE
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation				10d. Inside City Limits
	Maryla	to	MD BALTIMORE		STERSTOWN				1 □Yes 2 No
	ith the or 28a	Directo	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
	eath w	erail	302 CANTATA COURT #205 11. Marital Status 12. Was Deceden	t Ever in U.S. 13	Was Decedent of H	21136	pecify Yes or No-	USA 14. Race - Ameri	ican Indian.
9	after d or Item niner	Funeral	Armed Forces 1 □ Never Married 2 M Married 1 □ Yes 2 M	1No	. Was Decedent of H If Yes, specify Cuba	Specify:	o Rican, etc.)	Black, White	, etc.
21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. Id other then "netural", or flems 23a or 28a-f show or other then "netural" or flems 23a or 28a-f show event, it a Macifical Examination at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No		101	Specify:	WHITE
715-	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	rking	. Kind of Business/Ir	loustry
21	ygiene ygiene ner the	Com	4	MEC	HANIC	40 14-15-1-1-1-1		NGINEERIN	â
altimore, Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Items 23a or 28a-f ehow aumatic event, the MacJost Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) MAYER	KIR	NOS	MARIA	ne <i>(First, Middle, Mai</i> R	·	CHERNOKOFSKY
ary	2 should and Miles mari	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street		ural Route Number, C		The state of the s
e,	1 and 2 Health em 27 ther tra		EMILYA KIRNOS / WIFE 20a. Method of Disposition	302 20b. Place of Disp		COURT #20	Date REIST	ERSTOWN, No. Location - City or T	
TOL	Pages nent of h int: If its iry or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e cemetery, cr	ematory or other plac E HEBREW (REISTERST(
alti	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee		22. Name and Addre	ss of Facility SC	L LEVINSON	√ & BROS.,	INC.
8	205 29	. 111	23a. Part1. Enter the disease, or complications that cause				ROAD - PI	KESVILLE,	MD 21208 Approximate
3	Pnysician		shock, or heart failure. List only one cause on each Immediate Cause (Final	100 A		ig, 30011 23 021 3101	or respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or a	s a consequence of):	7				_
	Examiner	_	Sequentially list conditions, if any, leading to immediate cause. Enter Undervin	s a consequence of):					
	outed od ansit	Examiner	Cause (Disease or injury that initiated events	,					
90,	cate be executed oblysician and the burial-transit	i Ex		s a consequence of):					
68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	ledicai	d	-					-22-1011
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		□Ectopic pregnancy	,		23d. Date of deliver Month	very Day Year
P.O. E	that the dea led by the at detached fo	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown		Other (specify)			Worth	Day roal
	es that tigned by	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords	ław requires as been sign 2 should be						1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Micrown
Vital Records,	0 5 0	Completed					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ta		Be Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 € ath (Check only one)	1 ☐ Yes	2□ No
ζ	Physicien: this certific ral director,	2		tient 2 ER/Outpati		ier: 4 🗌 Nursing F			ify)
on c	ding P h. After funera	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	jury 28b. Time Jay Year) Injury	Wo	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division of	l or Attending after death. Director: Aftel I in by the fune	ertification:	3 Suicide 6 Could not be 28e. Place of li	njury - At home, farm, s etc. <i>(Specify)</i>	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	Hospitel or A 14 hours after Funeral Directely filled in by	O,			- Ab		and due to the source	-(a) and manner as	atatad
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or					
	To th To th	M	29b. Signature and title of certifier		29c. Licens		29d.	Date signed (Month	, Day, Year)
	0		30_Name and address of person who completed cause of		D 4	1653		8/31/05	
	Ü	1			DE Cente	7653 Mowa A	ND		
	Sta		St. Pate filed (Month, Day, Year) 32. Regis	et Sute Z strar's Signature	Conde				
	Regist	ali	SEP 0 2 2005 Dec	has to					

nysicia		1. Decedent's Na	me (First, Middle,	Last)								2. Date of		ne _{No.} 2 (3. Time of Death
Medic		Lawren	ce Edwar	d Kucl	ken							Augu	st 2	23, 2	2005	12:27 P
xamin			(If not institution,							Location	of Death				inty of Death	
			Hatbrim			-			umbi		0411			Howa		
neral ector		5. Social Security 307-40 Usual Residence	-6442	6. Sex 1 🙀 M 2			ast birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of (Month, July	Day, Ye		2 Ind	place (State or Forei Intry) Lana
ie p		10a. State	10b. County Howard				, Town or Lo									10d. Inside City Limit
9	Director					Co.	lumbia					_	10.	0	-6110	1√1 Yes 2 1 N
edical Examiner must be notified at	급	10e. Street and N	Hatbrim	Terra	ce				ip Code 1046					USA	of What Cou	untry ?
rum.	Funeral	11. Marital Status		12. W	as Decedent E	ver in U.S	S. 13.	Was Dece	edent of H	ispanic Ori	igin? (Spe	ecify Yes or Rican, etc.)	No-		Race - Amer	
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al Ex	ed by	3 ∐ Widowed	4 Divorced 15. Decedent		ear or Dates:	1	16a. Dece			ation			166		Wh: f Business/li	ite
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4	Com	Clementary/36	condary (0-12)		5+	*/	Resea	arch	Anal	yst					- Cuci	
or other traumatic event, the Mccical	Be		e (First, Middle, L	ast)						18. Mothe	er's Name	(First, Mid	ldle, Mai	den Sum	name)	
natic	2		Kucker		-(-4)		1 40b Mail		/01			ogows		·	wn, State, Zi	- 0- 1-)
traur			Name/Relationsh Ohlenka												wn, smare, 21 diana	46356
any injury or other tra		20a. Method of D	Pisposition	• •		20b. Pl	lace of Dispo emetery, crei	osition (Na	me of	ا ام	E	Date	200	. Locatio	on - City or T	own, State
ry or			2 ⊠Cremation n 5 □ Other <i>(Sp</i>		al from State	1	sapeak		-		8/29	/2005	E	Belts	sville	, MD
any inju	1	21. Signature of	Funeral Service L	icensee	11		22	2. Name a	ınd Addres	ss of Facilit			_		Homes	·
2 9		Ju	Sendely	~	Torini	110		5555	Twin	Kno1	1s R	oad, (Colu	mbia	, MD	21045
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ins certificate has been agreed by the executing projecter and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Chronic 25. Was case ref	conditions, immediate deriying or injury nts n) Last ent pregnant 12 months? 2 \(\triangle \) No wn ferred to medical	c. d. 23c. If 16 46 95 95 95 95 95 95 95 95 95 95 95 95 95	Due to (or as a Due to (or as a Due to (or as a yes, outcome o Live birth Pregnant at Unknown ing to death bu	a consequence of pregnar 2 Fetal time of de	uence of): uence of): uence of): ncy death 3[eath 5[□Ectopic p □ Other (s inderlying	oregnancy pecify) cause give	en in Part I 26. Place er: 4 □ Nu	of Death	23e. D 1 24a. W an 1 1 2 Ye	Yes tas an utopsy enformed as 2	2 No 241	ontribute to one of the contribute to one of t	the cause of death? bably 4 MUnknot opsy findings availal ampletion of cause of
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				For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artment of F	lealth and <i>Death</i>	Mental Hygi	ene 2005	28761
	7 1/4	Physici	_	1. Decedent's Name (First, Middle, Last Sherri Kil Yom Ly						2. Date of Death August 3	1 Day 2005 Year	3. Time of Death 12:50 a M
		/Medio Examir		4a. Facility Name (If not institution, give			70	4b. City, Town, o		ath	4c. County of Deal	
		Funeral	- Na	Gilchrist Center 5. Social Security Number 6. Se		7. Age (In yrs. i 34		If Under 1 Year Months Days		n. (Month, Day,	Year) 9. Birt	thplace (State or Foreign buntry)
8	'a'	Director		242-25-3843 Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		Mar. 8,	19/1 601	10d. Inside City Limits
A O		he Maryl 8a-f eho	Director	Md. Harfor	đ		A	bingdon		110	og. Citizen of What Co	1 Tyes 2 No
12:50AM		deeth with the Maryland me 23a or 28a-f ehow rmat be notified at		10e. Street and Number 420 Oakton Way					1009		U.S.A.	
20	36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "neture!", or iteme 23a or 28a-1 ehow empt hojury or other traumatic event, the Marical Expanding from the notified at anoth loyer.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 D Yes If Yes, Give Year or Da	2 □ No ∍		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☐ No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
3	21215-0036	thin 72 hou e. an "neture I Macical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ication le <i>completed)</i> College (1-	4or 5+)	(Give lite. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of w	orking 1	6b. Kind of Business/	Industry
8	1d 21	e filed will Hygien other th	Be Con	17. Father's Name (First, Middle, Last)	4		homen	laker		ame (First, Middle, M	own home	
(00)	Maryland	should by the Ments marked imatic ex	ToE	Gary David Boe 19a. Informant's Name/Relationship (7)	rpe, Print)		19b. Mailin	g Address (Street		Om Chu Rural Route Number,	City or Town, State, 2	Zip Code)
76	e, Ma	1 and 2 : Health ar em 27 le ther trau		Frederic Lynes/hu	sband	20b. P	lace of Dispo	sition (Name of		ingdon, Md	. 21009	Town, State
L)	altimore,	Pages Iment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			view C	ratory or other place Crematory	09,		Baltimore,	
3	Ball	Depart Import eny in		21. Signature of Funeral Service Licens	///	1	5		Funera.		Bel Air, I	
7	-	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that cannot cause on ea	used the death	Do not enti		g, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	1	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):		CCK			Just
		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequ	uence of):		-		-	
	8760, ~	cate be executed physicien and the burial-transit		that initiated events resulting in death) Last	Due to (d	or as a consequ	uence of):					
	Вох 6	certifi ding	Physiclan/Medical	in the past 12 months?		nth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
	ls, P.O.	res that th signed by t be detach	by	9 ☐ Unknown N Part II. Other significant conditions co	ntributing to de	ath but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to s 2 No 3 □ Pr	the cause of death?
	Division of Vital Records,		Completed							24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings available completion of cause of
	Vital		Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2	EB/Outpation	oth		eath (Check only one)	11
	on of	ding Phy	tion: To	27. Manner of Death 12. Natural 5 Pending		f Injury b, Day Year)	28b. Time of Injury	28c. Injur Wor	4 Li Huisiiig	28d. Describe how		HOSPICE
	Jivisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildin	of Injury - At ho g, etc. (Specify	eme, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
		Hoepital 4 hours Funeral 1ely filled	edicai Ce	(Check only 2 Medical Exam	nar: On the ba	sis of examinat					use(s) and manner as te and place, and due	
		To the To the complex	Med	one) 29b. Signature and title of ceptifier	and mann	er stated.		29c. Licens		_ 0	d. Date signed (Monti	
		6		30. Name and address of person who c	ompleted cause	of death item	23a) (Type,	Print)	11 00		tugust. Boltz	31,2005
) Sta	te_	31. Date filed (Month, Day, Year)	1 22	ar's Signal	ture		14. C.	miles ST.	Dolta	prd exe
		Regist	_	SEP 0 2 21	005	alling.	KA	rack)				

			1 - For State Registramend ite	H // LIAN LII	aryland / Dep g 847 9/0%	artment of l	lealth ar <i>Death</i>	d Mental	Hygie Reg.	ne 20	05	28762
d	Physic	ian	1. Decedent's Name (First, Midd	-,,				Mont		Day	Year	3. Time of Death
	/Medi	cal	Elsie Helen 4a. Facility Name (If not institution			T 41 00 T			ember		2005	7:35 AM
	Exami	ner	St agnes	Hospital			more			4c. County	of Death	
	Funeral Director		5. 219-80-905 6 217-03-7955	1 1 M 2 TE	ge (In yrs. last birthday 88 Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Date Min. (Mon Jul	of Birth th, Day, Ye y 23,	^{ar)} 1917	Count	ace (State or Foreign try) yland
	nyland how	_	Usual Residence of Decedent 10a. State 10b. Count	/	10c. City, Town or L	ocation					10	Od. Inside City Limits
	Ba-f	cto	Maryland		Baltimo	re						1 X Yes 2 No
	it to	Dire	10e. Street and Number			10f. Zip Code			10g.	Citîzen of W	/hat Count	try?
	ath v	E.	3502 Clarenell			2122				USA		
036	urs after de al', or Item Exeminer	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 ▼Widowed 4 □ Divorcei	If Yes Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	ispanic Origin In, Mexican, P Specify:	? (Specify Yes uerto Rican, et	or No- c.)		- America k, White, e Wh	
1215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-I show other traumatic event, the Madical Exeminer must be notified at	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	5+) (Give	edent's Usual Occup e kind of work done DD NOT use retired	ation during most of f)	working	16b	. Kind of Bus		
27	Hygie		9 17. Father's Name (First, Middle)	(act)	Home	maker	40 14-45-4-	N			Home	
Maryland	d be i	Be c	Frederick Elen	·				Name <i>(First, M</i> 1sie Kr			9)	
<u></u>	should nd Me mark matic	7	19a. Informant's Name/Relations		19h Mail	ing Address (Street					State Zin	On de l
	and 2 : ealth ar n 27 le		Sharon Haves									
altimore,	s 1 and 2 f Health item 27		20a. Method of Disposition	Daugh	20b. Place of Disp	Rockhill osition (Name of		Date Date	1more 20c.	Mary Location (Land City or Tov	21229 vn, State
Ē	Pages nent of h int: If ite iry or of		1 🖾 8urial 2 □ Cremation 4 □ Donation 5 □ Other (5		-	matory or other placed dge Mem.	´ I	/3/2005	F11	ridge,	Mar	wland
Dall	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr 00ce.		21. Signature of Eugeral Service			2. Name and Addres Sterling 736 Edmo	s of Facility Ashto	n Schwa	b Fun	eral H	Home,	Inc.
E es	A		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that caused	the death. Do not en	ter the mode of dyin	g, such as car	diac or respirat	ory arrest,	SVILLE		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Acut	11/	rardial	Infa	rctio	1			Onset and Death
3	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. High Due to/(or as	a consequence of):	Pressu	e					
68/60,	ficate be executed physicien and is the burial-transit	edicai Examiner	that initiated events resulting in death) Last	C	a consequence of):							
	- CO 00	Medi	IS SELVING									
P.O. Box	law requires that the death certifias been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			_	23d. Date Mont		V Day Year
	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the u	nderlying cause give	on in Part I.		Did tobacc			cause of death?
or vital Records,	The ste h page	Completed						-	Was an autopsy performed?	pri de	or to come ath?	sy findings available pletion of cause of
<u> </u>	iclan: T certificet rector, pa	Be	25. Was case referred to medica examiner?				26. Place of	Death (Check o	-	40	1103 2	2)40
> =	\$ w 0	ြို	1 ☐ Yes 💥 No	Hospital: 1 Inpatie	nt 2 ER/Outpatier	nt 3 DOA Othe	4 Nursin	g Home 5	Residence	6 🗆 Other	(Specify)	
=	ing After	ation:	27. Manner of Death 1 Natural 5 □ Pendir 2 □ Accident investi	gation	y Year) 28b. Time o	Work	at ? ′es 2 □ No	28d. Desc	ribe how in	jury occurre	d	
DIVISION	Hospitel or Attend 24 hours after death Eunerel Director: /	Certification:	3 Suicide 6 Could 4 Homicide determ		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Locati City o	on (Street r Town, Sta	and Number ite)	or Rural i	Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edicai	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	n occurred at the time vestigation, in my op	e, date and pl inion, death o	ace, and due to	the cause me, date a	(s) and mani nd place, an	ner as stat id due to t	red. he cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifie	r		29c. License	number		29d. D	ate signed	(Month, Di	ay, Year)
1	1/		oday. R	· Nausur	etis.	D51	119		Se	otemb	er 1	, 2005
E)		30. Name and address of person	who completed cause of di Hospital,	eath (Item 23a) (Type, 900 Cate	Print)	, Ba	Himore	, mī	2	1229	, 2005
4	Sta Registr	te ar	St. Agnes 31. Date filed (Month, Day, Year) SEP 0	2 2005 32. Registra	ar's Signature	back						

Barbara Lore 05-05927 RPD

egna	ırd	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.								
	1 - For State Registrar		State	of Maryland / Depa Cer	artment of Health and M rtificate of Death	¶ental Hygi ®	ene g. No. 2 (005	287	76
cian dical	1. Decedent's Name (i Barbara	First, Middle G.	Loregnar	đ		2. Date of Death Month August) 005	3. Time of D. 1536 p	
iner	4a. Fecility Name (If no Prince Geo		•	,	4b. City, Town, or Location of Death Cheverly		4c. County Princ		orge's	
al	5. Social Security Num	ber 72	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Year)	9. Birthpl	ace (State or F	Foreign

Funer Director

Phys /Me Exan

with the Maryland other then "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at filed within 72 hours after death permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumstic event <u>once.</u>

Baltimore, Maryland 21215-0036

66 Yrs. Sept. 26,1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location NY Nassau Freeport Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18 Gerald Ave 11520 USA Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cecil Borde Una (unk.) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde A. Loregnard / Husband 18 Gerald Ave, Freeport NY 11520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Mucurapo Cem. Sept. 8, 2005 St. James 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funers! Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examiner

Completed by Physician/Medical

Be

၉

Certification:

Medicai

Sequentially list conditions, Tany, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

²², Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple injurie Due to (or as a consequence of)

Due to (or as a nonsequence of)

Due to (or as a consequence of)

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

4 Homicide

29b. Signature and title of certifier

29a. Certifier

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea

Licensee Victor Doda

2 Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Trinidad

10d. Inside City Limits

Black

Own Home

Inc. MD 21230

¥es 2 □ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 🂢 No 3 Probably 4 □Unknown

Driver of motor rep: I that collided

24a. Was an autopsy performed? 10 Yes 2□No

24b. Were autopsy findings available prior to completion of cause of d → h?

1 Yes 2□ No

25. Was case referred to medical examiner?
1 A Yes 2 No 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Natural
2 Accident 5 Pending investigation 8-31-05 2:25 6 ☐ Could not be 3 Suicide

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

at Location (Street and Numbed or Aural Acute Number, City or Town, State) Brown Station Rd and Tohn Redgers Blvd, uppe Mariboro

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) September 1, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

LI MID 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) SEP 0 2 2005

32. Abgistrar's Signatur A September

			1 - For State of Maryland	Department of Health and M Certificate of Death	lental Hvaier	9
4.	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Logg JR 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	08	Pay Year 3. Time of Death 4c. County of Death
Short St.	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last 108-24-4424 10XM 2 F 75	birthday) If Under 1 Year If Under 24 Hrs. Yrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	N/A
	the Maryland 28a-f •how	rector		own or Location Severn	100	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural" or Items 23a or 28a-f show event, the Medical Examinar must be notified at	d by Funeral Directo	26 Burns Crossings Road 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X 9 2 No II Yes, Give Year or Dates:	21144 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F		USA 14. Race - American Indian, Black, White, etc. Specify: White
ınd 21215-0036	be filed tal Hygi d other	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		(First, Middle, Maide	,
, Maryland	d 2 should th and Mer 7 to marke traumatic	To	Harry W. Ledger Sr. 19a. Informant's Name/Relationship (Type, Print) Glenn Allen Ledger (son)	Barbara 9b. Mailing Address (Street and Number or Rura. 2016 Orchard Avenue, J		y or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and Department of Heati Important: if Item 2 eny injury or other 2008.			of Disposition (Name of terry, crematory or other place) Mont Cemetery 200	ate 06 20c. 05 Dav Stallings	Location - City or Town, State /idsonville, Maryland Funeral Home, P.A.
A SECTION OF THE SECT	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	traumatic bain in		Approximate Interval Between Onset and Death
8760,	rate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence cause). Due to (or as a consequence cause). Due to (or as a consequence cause).	SO OT):	Pril	
Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		23d. Date of delivery Month Day Year
Records, F	v requires that been signed should be de	ρχ	Part II. Other significant conditions contributing to death but not resulting	r in the underlying cause given in Part I.	1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
<u> </u>	The ate h page	Be Completed	25. Was case referred to medical example?	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 N	24! Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of V	<u>ਦ</u> ਦੁਲ	Certification: To I	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C 27. Manner of Death 1 Natural 5 Pending (Mogth, Day Year) 2 Accident investigation (No Strict Control of Country)	Outpatient 3 DOA Other: 4 Nursing Hom Time of Injury at Work? The of Injury at Work? The of Injury at Work?	e 5 Residence Bd. Describe how inju	
É	i di di		4 Homicide determined 286. Place of injury - Al home, building, etc. (Specify) 29a. Certifier 11 Certifying Physician: To the best of my knowled	Street School of the time date and place as	ad due to the cause	and Number or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral is completely filled	Medical	29b. Signature and title of certifier	29c. License number	d at the time, date an	ate signed (Month, Day, Year)
	Sta Registr	-	30. Name and address of placen who completed cause of death (Item 23a (Can Supplemental Suppleme	(Type, Print) MD 2120		<i>j-1/0</i>

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ruth Minnie Lacher 4:56 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltmore
Hunder 1 Year | If Under 24 Hrs. St. Agnes
5. Social Security Number N/A **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar. 17, 1921 9. Birthplace (State or Foreign Days Hours 1□M 2**2**F 231 30 4725 Yrs. 84 Director Virginia Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be natified at Maryland Director Baltimore 1 Yes 2X No Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Claridge Avenue or iteme 23a U.S. 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene. other than "naturel", or ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No ģ Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 8th Retail Stores permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event, ORRs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. D. Hogge Annie Belle Thrift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maude Yvonne Ackley / Daughter 1408 Claridge Avenue Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 9/1/2005 Baltimore, Maryland 21. Sign use of Juneral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or sent shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Varantar Diseace **Physician** disease or condition EALS resulting in death) /Medical Examiner S. u.s.ni.illy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy 1 Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hugust 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUS LN Esporite 900 Caton Remove 900 Caton Avenue Saltmore 31. Date filed (Month, Day, Year) 32. Digistrar's Signature State Registrar

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		1 - For State of Maryland / Depa	rtment of Health and Mer tificate of Death	ntal Hygien	ZUUD /8/66
Physici	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month D	ay Year 3. Time of Death
/Medic Examin	al.	Frank Joseph Matecki 4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tug ust	3/ 2005 /343 M
CXamili	lei	Franklin Square, Hospital	Rosedale		Balfimore
Funeral		5. Social Security Number	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. 7.	Date of Birth (Month, Day, Yea WY 30,	9. Birthplace (State or Foreign Country) 1920 Maryland
Director		Usual Residence of Decedent		ucy 30,	1920 marykana
arylan show	č	10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M 28a-f	Director	Maryland Baltimore Ba	ltimore	10a. C	Citizen of What Country?
th with 23a or	al Di	4249 Darleigh Road	21236		U.S.A.
ar deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. WArmed Forces? 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S	Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
JSO Jrs after Jr, or I	by F	1 □ Never Married 2 M Married 1 M Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced 1 Year or Dates: (₩₩ 11	☐ Yes 2 No Specify:		Specify: White
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Mar d 2 sho h and 7 is m traum			g Address (Street and Number or Rural Ri Darleigh Rd., Balt	-	
s 1 and f Healt itam 2		20a. Method of Disposition 20b. Place of Dispos			Location - City or Town, State
Page nent o ant: If ury or		'4 □Donation 5 □Other (Specify) Gardens o	6 Faith Cem. 9/3/20		
parlimore, Maryia permit. Pages 1 and 2 should Department of Health and Man Important: If item 27 is marka any injury or other traumatic 2002.			Name and Address of Facility Schin 705 Belair Rd., Bal		
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the de	hysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		,
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wrequires that sheen signed to should be detailed.				1 🗆 Yes	2 ØNo 3 ☐ Probably 4 ☐ Unknown
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ysicie	To B	examiner? 1 ☐ Yes No	Other		6 ☐Other (Specify)
ding Phy h. After this funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	. Describe how in	ury occurred
or Attanding after death. Diractor: Afte in by the fune	ficati		M 1 ☐ Yes 2 ☐ No	Location (Street a	and Number or Rural Route Number.
al or A	Certification:	4 Homicide determined building, etc. (Specify)	or, radory, order	City or Town, Sta	
To the Hospital or Attanding Physicien: within 24 hours alter dearh. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death 2 Madical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, and estigation, in my opinion, death occurred a	due to the cause(at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate/signed (Month, Day, Year)
* W		15.101 ms	15 es 00000	18	131/05
lox,		30. Name and address of person who completed cause of death (Item 23a) (Type, F R B C G S S S S S S S S S S S S	Klin Square Dri	ve Ba	Himore, Md 21237
Sta Registr		31. Date filed (Month, Day, Year) SEP 0.2 2005 32. Feetrar's Signature	ali		

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month LOROTHU MACKERT 5:00 AM 2005 /Medical 4a Fecility, Name (If not institution, give street end number) KAST Rount Call ater, 1046012 Nocth Pt Rd 4b. City, Town, or Location of Death 4c. County of Death Examiner + Nursing Center, Bolfinger E DALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months 1□ M 2□ F 84 Virginia 215-22-5112 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth end Mentel Hygiene. Important: If them 27 is marked other than "natural", or thems 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Madical Examinat must be notified at 10d. Inside City Limits Md. n/a Baltimore Funeral Director 1∏Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2606 Goodwood Road 21214 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Augustus Harris Beulla unknown ^{19a,} Informant's Name/Relationship *(Type, Print)* Sharon Stout (Daughter) 19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Gode)* 116 N. Paca Street, Apt.203, Baltimore, Md. 21201 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md. Veterans Cemetery 09/06/2005

Crownsville, Md. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · Atherosclerotic Cardiovascular Disease Examiner Examiner physicien end s the buriel-trensit The law requiras thet tha death certificate ba axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ cartificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartifica tha funeral director. Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menner of Deeth 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 142 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the To the To the I 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Back River Neck Rd MAUMOUI) 201-109 ARIQ 31. Date filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005

				Oldio of Marylar	•	cate of	f Death	Re	eg. No.	105	28/68
	Diversities		1. Decedent's Name (First, Middle, Last)	Λ .	.1			2. Date of Deet	h Day	Year 3	3. Time of Death
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ε	1 8		Augsburg Lutheran		7 . 4 t n . 1 1 1 1 1	nder 1 Yea	Lochearn	O Date of Dist.		imore	
20 pm	Funeral Director		5. Social Security Number 6. Sex 215-05-7658	7. Age (In yrs. 94	Yrs.		s Hours Min.	8. Date of Birth (Month, Day, May 30	911	Maryla	e (State or Foreign nd
CP	land	-	10a. Stete 10b. County	10c. Ci	ty, Town or Location					10d.	Inside City Limits
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. 0	th with the 23a or 28a set be not	Funeral Director	10e. Street end Number 636 Kensington Av	enue	10	. Zip Code 21	146	11	0g. Citizen of V U.S		?
1/05	020	፳	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	I2. Was Decedent Ever in U Armed Forces? 1 ∰ Yes 2 ☐ No If ¥es, Give Year or Dates:	VII 10 Y	es 2∭No	Hispenic Origin? (Spe ban, Mexican, Puerto o <i>Specity:</i>			ce - American ck, White, etc. v: Whit	
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3		-	19a. Informant's Name/Relationship (Type		19b. Mailing Add	dress (Stree	et and Number or Rure				ode)
ame	M 2 diff g 27 ls r tra		Veronica Collier	(Daughter)	636 Kei	nsingt	ton Ave. Se	everna P	ark, Mo	1. 2114	4 6
3	Baltimore, Nami: Pagas 1 and: Department of Health Moorbant: if tem 27 in the 171 into Injury or other tr		20a. Method of Disposition 1	emoval from State	Place of Disposition cemetery, crematory aklawn Cer	or other pl		Date 3	20c. Location - Baltin		
{	Baltimo parmit. Paga: Department of Important: If I any Injury or pnca.		21. Signature of Funeral Service License	and and			tssoffacillynial . Fort Ave				30
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	D. E a daa ha da nad fo	Physician/	Part II. Other significant conditions conf	tributing to death but not res	sulting in the underly	ing cause g	given in Part I.	23b. Did to	bacco use cor	ntribute to th	e cause of death?
	P.O. hat the od by the datacha	E						1 □ Ye	s 2 No	3 Probab	ly 4 Unknown
	Division of Vital Records, P.O. Box ior attending Physician: The law requires that the death car after death. Director: Attar this certificate has been signed by the attending in by the funeral director, page 2 should be deteched for use	Completed by						24a. Wes en	n eutopsy ned?	availal	autopsy findings ble prior to letion of cause
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	andin ath.	atio	1 ØNetural 5 ☐ Pending investigation		м		□Yes 2□No				
	or Atte		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa fy)	ctory, office	е	28f. Location (St. City or Town	reet and Numb , State)	er or Rural Ro	oute Number,
	ottai o	ပီ	00 0 48		malada de de			- 1 - 2 - 2 - 2			
	Hospital 24 hours Funeral ataly fillad	edical Certification:		ician: To the best of my kno er: On the basis of examina and manner stated.							
	Division of Vital Re To the Hospital or Attending Physician: Tha is within 24 hours after death. To the Funeral Director: After this certificate ha complately filled in by the funeral director, page	_	29b. Signature end title of certifier	and mainty states.		29c. Licer	nse number	29	9d. Date signed	d (Month, De)	v, Year)
	1			<u> </u>			037573		AUTUS	PS +	7005
	and de	-	30. Neme and eddress of person who con	mpleted cause of death (Iter	n 23a) (Type, Print)		0				4
	M, ad		Sef Zlack	75 (DM)	Max	Sty	Keisters	tan 1	NO ZIT	36	
	Stat	e	31. Dete filed (Month, Day, Year)	32 Registrer's Signa	ture foots	, C					

		State Registrar		ertificate of Death	Reg.		8169
Physic	ian	1. Decedent's Name (First, Middle, Last) Charlotte Irene Me	cCallum		2. Date of Death Month	Day Year	Time of Death
/Medi Exami	cal	4a. Fecility Name (If not institution, give street and		4b. Cily, Town, or Location of Death	AUGUST	4c. County of Death	43 1 "
	iei	GOOD SAMARITAN HE		BALTIMORE		BALTIMOR	
Funeral Director		5. Social Security Number 215-28-3188 0. Sex 1 □ M ≥ 2 Usual Residence of Decedent		Months Days Hours Min.	8. Date of Birth (Month, Day, Ye JUNE 27	,1927 Mary	(State or Foreign Land
land ow		10a. State 10b. County	10c. City, Town or I	Location		10d. I	nside City Limits
Many a-fsh	to	Maryland N/A	Balti				Yes 2 No
h with the 13a or 28i	Funeral Director	10e. Street and Number 1702 Ivanhoe Avenue		10f. Zip Code 21 21 2	10g.	Citizen of What Country?	
and ZIZISDOUSO be filed within 72 hours after death with the Maryland hat Hygiene. do other than "natural", or iteme 23a or 28a-f show event, the Medical Exerticat must be notified at	by Funera	Ame	Decedent Ever in U.S. 13 d Forces? /es 2 No s, Give or Dates:	. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 Yes No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Ir Black, White, etc. Specify:Black	ndian,
Baltimore, Maryland 21215-UU36 bernit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Exert DRE.	Completed	15. Decedent's Education (Specify only highest grade comple	ted) 16a. Dec (Giv iife.	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	king	t. Joseph	
other	To Be Co	17. Father's Name (First, Middle, Last) Jospeh Casterlow	als M	18. Mother's Nam	ne (First, Middle, Mai Smith	den Surname)	
Mary nd 2 shou alth and M 27 ie mar r traumat	-	19a. Informant's Name/Relationship (Type, Print Dana McCallum/ Son	19b. Mai 4702	ling Address (Street and Number or Ru 2 Ivanhoe Ave Ba	ral.Route Number, C. altimore	ity or Jown, State, Zin Co. , Mary I and	^(e) 21212
Darkim Ore, INarylar partitions and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic enones.		20a. Method of Disposition Mc☐ Burial 2 ☐ Cremation 3 ☐ Removal I 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disc cemetery, ch maryland	position (Name of emalory of other place). National Mem.	PR La	c. Location - City or Town, urel, Maryl	State and
Dalti permit. Departn Importa any inju		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Ch. 5240 Reistersto	atman-Ha wn Road	rris Funer Baltimore,	al Nome Md2121
		Shock, or heart failure. List only one cause	on each line.	nter the mode of dying, such as cardiac		Inte	proximate erval Between set and Death
Pnysician /Medical		disease or condition resulting in death)	e to (or as a consequence of):	troial wear	CTION		
eath certificate be executed attending physician and for use as the burial-transit a	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of):	C CARDIOVASCU	LAR DIS	EASE	
The law requires that the death certific the law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
LS, T.	by	Part II. Dther significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the ca	14
VICAL RECOLDS, sicien: The law requires t certificate has been signe irector, page 2 should be	Completed				24a. Was an autopsy performed	24b. Were autopsy f prior to comple death? No 1 □ Yes 2	
	To Be		1 ☐ Inpatient 2 EF/Outpatie	ent 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how i	e 6 Other (Specify)	
I or Attending Physical Color after death. Director: After this in by the funeral d	Certification:	1 Natural 5 Pending (2 Accident investigation 3 Suicide 6 Could not be	Month, Day Year) Injury Place of Injury - At home, farm, s	Work? M 1 ☐ Yes 2 ☐ No		t and Number or Rural Ro	ıte Number.
pital or A burs after erel Dire		4 Homicide	ouilding, etc. (Specify)	ath occurred at the time, date and place,	City or Town, S	tate)	
e Hos 24 hc e Fun letely	Medical	(Check only 2 Medical Examiner: On t	he basis of examination and/or i manner stated.	nvestigation, in my opinion, death occur	rred at the time, date	e(s) and manner as stated and place, and due to the	cause(s)
To th within To th	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day,	
$\langle \rangle$		30. Narte and address of person who completed	cause of goath (Item 23a) (Type	D D S 89 3 5	Ac	19051 30,2	ω <u>\$</u>
`		KERITH JOSEPHI	5601 LOCH R	AVEN BLUD BA	LTIMORE	, MD 212:	39
St Regist	ate rar	SEP 0 2 2005	32. Registrar's Signature	Sel .			

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month eborah Tichelle 2:00PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA BALTIMORE Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country). 8. Date of Birth (Month, Day, Year) **Funeral** Months 213-80-8887 1 □ M 2**X**F 43 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location , or Items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2824 USA Hart 21218 oad death Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ HUCAN AMELICAN 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 le marked other than any injury or other traumatic event, the Magnetic event, the Magnetic Elementary/Secondary (0-12) College (1-4or 5+) irses Aide 1244 Trivate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JeffRies ewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Moskey SIS-ER 3027 LORMount MARJAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dynation 5 ☐ Other (Specify) Mt. Zion CANS COUR, 22. Name and Address of Facility
WARRY M. WALLACE FLINERAL SERVICE
3405 W. FRANKLIA St. BAHIMORE MARGHAD 31339 21. Sign ure of Funeral Service Licens 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. H. V. Nephroputty Approximate Interval Between Onset and Death and Death Due to (or as a consequence of): **Physician** 4 years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, by Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown signed by the atte Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After t Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by within 24 hours after To the Funerel Direct 4 T Homicide Technifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Aug. 28, 2005 AT 2438946-F46 ddre of perso completor cause of death (Item 23a) (Type, Print) Memorial MD. VGUYEN Union THY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 02 2005 Registrar

RKD

05-05818 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 For State Registrar 28771 1-Certificate of Death 2. Date of Death Month 1 Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** McCormick Mae Annie AUGUST 29, 2005 4:40P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NA 1721 N.CAROLINE STREET BALTIMORE ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 11-10-5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F N.C. Yrs 90 Director 219-28-6814 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Madical Examiner must be notified at X Yes 2 No Director Baltimore NA Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural" ~ "" eny Injury or other treumatic average. 21213 1721 N. Caroline Street USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) Colfege (1-4or 5+) J.H.H. Clerk 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mills Alston Josephine James 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8061 Woodhaven Rd., Baltimore, Md. 21237 Daughter Carole A. Weems 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State □XBurial 2 □ Cremation 3 □ Removal from State 9-9-05 Garrison Forest Vet. Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. Wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. March F.H. East 1101 E. North Ave Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examine use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed ed by the attending physicien and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) Yes 2 □No 9 Unknown 9 Unknown this certificate has been signed by all director, page 2 should be detact Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 X No After this certification, funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) SCENE Certification: To 1 X Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 XNatural 5 Pending To the Hospiter or within 24 hours after death.
To the Funeral Director: Aft 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and O.C.M.E. AUGUST 29,2005 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date fifed (Month, Day, Year)

SEP

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32 Registrar's Signature

			For State	State of Maryland /					00770
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate	of Death	2. Date of Dea	eg. No2005	3. Time of Death
	Physici /Medic		LILLIAN	V.	He G	laughN	Sept.	Day Year	9-05 AM
	Examin		4a. Facility Name (If not institution, give	street and number) 2 /		own, or Location of Death		4c. County of Death	
			5. Social Security Number 6. Se	x 7. Age (In yrs. last)	birthday) If Under 1	Del Hir. Year If Under 24 Hrs.	O Date of Birth		FORD
	Funeral Director			M 20 80		Days Hours Min.	8. Date of Birth (Month, Day)		place (State or Foreign ntry) HEY/AND
	and w		Usuat Residence of Decedent 10a. State 10b. County	10c. City. To	own or Location				10d. Inside City Limits
	Maryli fied a	tor	MARNAND	Ball	TIMOR	en.			12 Yes 2 □ No
	ith the	Olrec	10e. Street and Number		10f. Zip (1	0g. Citizen of What Cou	ntry?
	death with the Maryland rms 23a or 28a-f show rmst be notified at	Funeral Director		12. Was Decedent Ever in U.S.		1224		U.S.	A ·
ယ္	or Item		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No		ent of Hispanic Origin? (St fy Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White,	etc.
5-0036	72 hours after natural', or ite	d by	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		No Specify:		Specify: W	hitc
	in 72 n "nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	3a. Decedent's Usual (Give kind of work life. DO NOT use	done during most of work	king	16b. Kind of Business/In	dustry
2121	od with	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	BA	RMAID		Edgenere	2 Lounge
and	be file	Be	17. Father's Name (First, Middle, Last)		1/ 1 1	18. Mother's Nam		Maiden Sumame)	
Maryland	should nd Mer mark meric	L _O	WNKNEWN 19a. Informant's Name/Relationship (T)	pe, Print) & suchter 1	9b. Mailing Address		CNOWN ral Route Number	. City or Town. State. Zin	Code)
Ma	and 2 alth al 27 is er trau		Frances Supe	CZYNSKI	541 Ris	ing Sun A	COAD R	ISINA SUN	1 MD21911
ore	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumetic event, It a Madical Examinar must be natified at		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ F	Removal from State	of Disposition (Name tery, crematory or off	ner g(ace)		20c. Location - City or To	own, State
Baltimore	Pa ment ury		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature # Funeral Service Licens	Une	enmount	Cen Sept	2,2005	DA/timore,	MARYLAND
Ba	permit Depar Import any in		V1922	· ·	7050	Address of Facility PL N Z A CONKING	STREET	B+10 Mit	21224
			23a. Pant. Enter the disease or composhock, or heart failure. List only o	ications that caused the death. Done cause on each line.	o not enter the mode	of dying, such as cardiac	or respiratory arm	est,	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition resulting in death)	. RESPIRATOR		due to			Onset and Death
B	/Medical Examiner		reserving in deality	Due to (fr as a consequence	boothis	the Pula	en el en	- 1	Few days
U	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ce of):		DISCAS	,	1-
	and end etrans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequenc	og of):				
8760,	ate be executed hysician and the burial-transit	Ical E		A	.6 01).				
9		70	IE EE WALE	7.					
Вох	ath utter or u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea				23d. Date of delive	ery Day Year
o.	0 0 0	yslc	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (spec	cify)			
Ω.	res that igned b be deta	by Pt	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cau	use given in Part I.	23e. Did tob	pacco use contribute to the	he cause of death?
ord	w require been si should b	ted					1 □ Y∈	es 2 No 3 Prob	pably 4 Unknown
of Vital Records,	2 2 2	Completed					24a. Was a autops perforn	y prior to co	psy findings available mpletion of cause of
tal		a	25. Was case referred to medical			26. Place of ⊋ at	1 ☐ Yes 2	2 ☑ No 1 ☐ Yes	2 No
Ţ	Physiclan: this certific ral director,	To B	examiner?	fospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA	Other		ence 6 □Other (Specif	iy)
o uc	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b (Month, Day Year)	Intury	c. Injury at Work?	28d. Describe ho	ow intury occurred	
Division	i or Attendi after death. Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,	farm, street, factory,	1 Yes 2 No		reet and Number or Rura	al Route Number,
ā	ital or A rs after al Direc ed in by	Cert	4 Homicide	building, etc. (Specily)			City or Town	, State)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	lge, death occurred at and/or investigation, i	t the time, date and place, n my opinion, death occur	and due to the cared at the time, da	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
	To the Within To the	Me	29b. Signature and title of Artifier	1 00 1 · 1	/ 29c.	License number	29	9d. Date signed (Month,	Day, Year)
2011	~		> Non	ul My Zos	39th MO. [) 19583	5	eptember	1,2005
3	0		30. Name and address of person who come and an uel M	· lazati	MD	8 LAWS	+ Rect Abel	-deen Han	1.2005 yland 2/01
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 0 2 2	32. Registrar's Signature	foods	•			

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrer 28773 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2005 **Physician** Elizabeth M. Miara 8:00 A.M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pasadena Anne Arundel 255 Magothy Bridge Road 8. Date of Birth (Month, Day, Oct. 2, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Min. Months Hours 1 M 2 X F Oct. 1907 97 192 14 3574 Pennsylvania **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show or then "neturel", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 K No Pasadena Director Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21122 255 Magothy Bridge Road Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2K No Specify: If Yes, Give 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then ' ury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Anna Papciak Stanley Trzcinski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
255 Magothy Bridge Road Pasadena, Maryland 21122 19a. Informant's Name/Relationship (Type, Print) 255 Magothy Bridge Road John J. Miara / son 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal frpm State permit. Page Department of Importent: If any injury or once. Glen Haven Mem. Park 8/30/2005 Glen Burnie, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. namuocus 4001 Ritchie Highway Baltimore, Maryland 21225 23a. part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Zhelmer's Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Et al. Carrying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after this certificate has been sinned but the funerel Director. After this certificate has been sinned but the funerel brieform that the completely filled in but the funerel brieform that the function that the funerel brieform that the funerel brieform that the function that the funerel brieform that the function that the funerel brieform that the function that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funerel brieform that the funer that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2. No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) eputy 29b. Signature and title of certifier 29c. License number Meles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 695 America mD ones, 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 200528774 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Hilda Myers 2005 26 3:05 A. August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Mariner Health Forest Hill If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 219 42 6752 1 □ M 2 1 1 F Director Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d Inside City Limits 10b County 10a State 28e-f show Examiner must be notified at Maryland 1 ☐ Yes 2X No Harford Director Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1614 Swallowcrest Apt. A 21040 U.S. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel, or Items 23e eny injury or other treumatic event, the Medical Examiner rust 1 once. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes. Give 1 Yes 2 No Specify: Specify: White ğ If Yes, Give Year or Dates: 3 ★Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Aid Daycare 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Judson Myers Ruby Sales ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3813 - 5th Street Henry Heisterhagen / son Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery \\ 8/31/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. ecome 4001 Ritchie Highway Baltimore, Maryland 21225 23a. P. f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** respect disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 □ No Year Day 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy performed? 2 No 1 ☐ Yes Physicien: director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 Dough 5 aug 13, 26, 2005 D32295 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chosopeake Dr. Bel Air MD 21014

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 2 2005

Baltimore, Maryland 21215-0036

32 gegistrar's Signature

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rat or		213-14-5736	6. Sex 7. 1	Age (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8 Min.	Date of Birtl (Month, Day 9/17/1	[9.	Birthpla Countr	ace (State or Fe y) Land
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	tor	MD N/	A]	Baltimo	ore								1 X Yes 2
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	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ∰gNo	J	Was Decedi If Yes, speci 1 Yes 2			? (Specif uerto Ric	ly Yes or No- can, etc.)]	I4. Race - A Black, W Specify: WI	/hite, et	c.
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	To Be C	17. Father's Name (First, Middle, L Vincent Metall	,	-						First, Middle,				
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J	-	Jonnata-	us			412 B	етат	r Koad	i Bal	Ltimore	· Ma	arylar	nd 2	1206
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AUGUST 30, 2005

NICOLA METALLO

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	1 - State of Ma	aryland / Department of Health and N Certificate of Death	Mental Hygiene	005 00776
	1. Decedent's Name (First, Middle, Last)	1 / -	2. Date of Death	UUO 3. Time of Death
Physician /Medical		AKES	AUG. 29	2005 5:50PM
Examiner	4 = 90 bt 46 tt 10 tt 1 tt 1 tt 1 tt 1 tt 1 tt 1 tt	4b. City, Town, or Location of Death	V	inty of Death
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Funeral Director	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Usual Residence of Decedent	10	1-19-07	Massachusetts
thow thow	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
O. C. C. C. C. C. C. C. C. C. C. C. C. C.	MD BALTIMORE	BACTI MORE		1 ☐ Yes 2 No
with the	10e. Street and Number	101. Zip Code 21234	10g. Citizen	of What Country?
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filer of the refer	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married 1 Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
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21215-003 ed within 72 hours (199)ene. It the Madical Exal. (1, the Madical Exal.).	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b. Kind o	f Business/Industry
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ary s main	19a. Info mant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rui	ral Route Number, City or To	wn, State, Zip Code)
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Marylan and Mental Hygiene. The Marylan Experiment rust be multiled at some. To Be Completed by Funeral Director	20a. Method of Disposition` 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other place)	Date 20c. Location	on - City or Town, State
timent thent:	* 4 ☐ Donation 5 ☐ Other (Specify)	Gardens of Faith Cin : 9-	3-05 Kose	tale, MD
Bal permi Depa Impo any ir	21. Signature/of Funeral Service Licensee	22. Name and Address of Facility	ALTIMORE, M	0.10.1
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Division of Vital Records, tall or attending Physician: The law requires the staffer death. The Livestor: After this certificate has been signed and in by the funeral director, page 2 should be deartification: To Be Completed by	4 Homicide determined 28e. Place of Inj building, et	ury - At home, farm, street, factory, office c. (Specify)	28f. Location (Street and Nu City or Town, State)	imber or Rural Route Number,
Spltal ours some seral!	29a. Certifier 1 🖫 Certifying Physicien: To the best	of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and	manner as stated.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical	(Check only 2 Medical Examiner: On the basis of and manner st	f examination and/or investigation, in my opinion, death occur	rred at the time, date and place	ce, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	P DALL & 29c. License number	29d. Date sig	gned (Month, Day, Year)
	Nun Allunding	1 1/3/cian D336	Y L Aug	. 302005
in	30. Name and address of person who completed cause of c	anh Provinces 13(Vel 317	B. Ot, mre	21259
State	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature		1
Registrar	SEP 0 2 2005	Every to Scorter		
DHMH 17 Boy 1/2001				

			For State Registrar	State of Maryland		nt of Health and Mate of Death		giene eg. No 200	5 28777
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)	C.	Parekt)	2. Date of Dea Month	28 200	5 3:40A.M
٦	Examin	Ğ.	4a. Facility Neme (If not institution, give s Oper Chusoplake 5. Social Security Number 6. Sex	Medical Cer	Her F.	y, Town, or Location of Death A C ler 1 Year If Under 24 Hrs.	B. Date of Birth	4c. County of D	eath Birthplace (State or Foreign
	Funeral Director		219-19-5147 19 Usual Residence of Decedent	M 2□F \$5	Yrs. Months		8. Date of Birth (Month, Day	20 Z	Country)
	e Marylan Ba-f ehow	ctor	10a. State 10b. County MD HARFOR		Town or Location Abin	igdon	·		10d. Inside City Limits 1 □ Yes 2 No
	ath with th	Funeral Director	2800 Meredit	h Ct.		21009		0g. Citizen of What	
340	72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f ehow of cal Examinational be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		pedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race · A Black, W Specify: 7	merican Indian, hite, etc.
$\mathcal{S}/\mathcal{A}\mathcal{S}/\mathcal{O}\mathcal{S}$ Baltimore, Maryland 21215-0036		Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of work	ing	16b. Kind of Busine	ss/industry
Ind 21	be filed wi ital Hygien id other th event, the	To Be Con	17. Father's Name (First, Middle, Last)	12	Jelt &	18 Mother's Name	e (First, Middle,	Maiden Sumame)	Doctor.
) laryla	2 should and Men is marks aumatic	오	19a. Informant's Na e/Relationship (Ty		19b. Mailing Addre	ss (Street and Number or Run	al Route Number	for the second	A KIND OF THEODY
8/05 ore, M	ges 1 and 2 of Health if item 27 i		DR. Dhovat U. 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ R	Parekh 20b. Pla cel	140 6000 ace of Disposition (N metery, crematory of	lame of	Date	20c. L cation · City	
8/28, Saltimor	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	EVAL	ISFUNE BA	ICHAPEL-18-30	0-05 L	Forest H	21050.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death.	Do not enter the m	FUNERACCIA ode of dying, such as cardiac		AIR, BNE	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	once of):	ia			
363101 8760,	certificate be executed utility by sician and ase the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		5101)			
# # 0. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mynths? 1 □ Yes 2 □ No 9 □ Unknown	d. 3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic		-	23d. Date of o	delivery Day Year
a rds, P	uires that n signed t ld be det		Part II. Other significant conditions cor	ntributing to death but not resul	ting in the underlying	g cause given in Part I.	23e. Did tol		to the cause of death? Probably 4 Munknown
-0	Th ate n page	Completed by			,		24a. Was a autops perform	y prior i	autopsy findings available o completion of cause of ? es 2 \(\) No
Dh of Vit	ng Physician: fter this certific neral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Who 27. Manny of Death 1 Viatural 5 Pending 2 Accident investigation	1	R/Outpatient 3 I		me 5 Reside	ence 6 Other (S	рөсify)
rekh, Division	of or Attend after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, facto		28f. Location (SI City or Town	reet and Number or n, State)	Rural Route Number,
Pa	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physical Canada only one)	sician: To the best of my knowner. On the basis of examination and manner stated.	ledge, death occurre on and/or investigation	ed at the time, date and place, on, in my opinion, death occurr	and due to the cared at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	min.		9c. License number 20060545		9d. Date signed (Mc	A CONTRACTOR OF THE CONTRACTOR
	500		30. Name and address person was	mpleted cause of death (Item)	23a) (Type, Print)	D0060545 ake Drive,	Bel Air	MD.	1014
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 0 2 200	2 Registrar's Signard	ие Дом	7		/	

		•	State Amend Item 5 per Registrar	State of Maryland / er fin G847 9-6-	Department of Health and N Certificate of Death	lental Hygier Reg. t	2005	28778
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		William		PCCK		9th 2005	5:04 AM
)	Examin		4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death		4c. County of Deat	h NIA
N.			The Johns HOPKINS		DUTINGE CITY pirthday) If Under 1 Year If Under 24 Hrs.	0. Date of Righ	0. 8:40	halasa (China - Farina
Ē	. Funeral Director		407-46-7434	2 F 7. Age (In yrs. last b	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	431	hplace (State or Foreign untry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limits
	Maryl f sho	ō	MI		Baltimore			1 Z ¥es 2 □ No
	the 28e-	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Co	untry?
	N with	D	362 Homeland	Southin	alala		USF	4
	deati	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or items 23s or 28e-f show aumetic event, It is Marked Examiliar in the marked at the marked in	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Though otoly	Specify:	thirte
Ö	72 ho	ted	15. Decedent's Educat (Specify only highest grade of		a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b.	Kind of Business/	Industry
7	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	9	01.1:	toppose
2	Hygier Hygier Ither th		17 Feshada Nama (Final Middle 1 ans)	4	4Xecutive	o (First Middle Maid	HOUNT	isement
Maryland	d d d	To Be	17. Father's Name (First, Middle, Last) Reck	5	18. Mother's Nam	e (First, Middle, Maid	en sumame) 🛶	K
ary	2 should and Men Is marke aumetic		19a. Informant's Name/Relationship (Type,	Print) 19	Db. Mailing Address (Street and Number or Rur	al Route Number, City	y or Town, State, Z	Tip Code)
	and 2 ealth n 27 I		Janis Keck /u	rife 3	62 Homeland Soi	theay	willy.	UD SISIS
timore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	como	of Disposition (Name of tery, crematory or other place)	Date 20c.	Location - City or	Town, State
Ē	Pag tment tent:		' 4 ☐ Donation 5 ☐ Other (Specify)	Me	tro Cornatory 9-8	-05	otto,	MD
Ba	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumetic once.		21. Signature of Juneral Service License	harch	12. Name and Address of Facility 12. AM 12.32 Michaelia	ler Dr. 3	ressur, P	A 18434
			23a. Part Enter the disease, or complicate shock, or heart failure. List only one of	tions that caused the death. Do	o not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cerebral Her	niation			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence				
	Examiner		Sequentially list conditions, if any, leading to immediate	Intractorial Due to (or as a consequence	Hemorrhage		-	30ms
	bed issit	ulne	Cause (Disease or injury		•			3 Colors
	xecul and al-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence				220175
68760	ificate be executed y physician and as the burial-transit		L d.					
		ledical						
Вох	Jeath certifi attending I for use as	an/N	230. Was decedent pregnant	If yes, outcome of pregnancy 1□Live birth 2□Fetal dea	th 3 Ectopic pregnancy		23d. Date of deli	
о С	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month	Day Year
P. 0.	uires that the dei signed by the a id be detached f	Phy	Part II. Other significant conditions contril	buting to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	signe signe d be	d by			,	1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Dinknown
COL	w requir been si should	lete				24a. Was an	24b. Were au	topsy findings available
æ	Physicien: The lav this certificate has al director, page 2	Completed				autopsy performed	prior to death?	completion of cause of
ta		Be C	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 ☑ 1 h (Check only one)	No I Tes	2 No
<u> </u>	ysicie is cer direct	To B	examiner? 1 Yes 2 No	pital: 1 Inpatient 2 ER/O	Othor	ome 5 🗆 Residence	6 ☐Other (Spec	cify)
0	Attending Physicien: r death. ector: After this certification the funeral director,		27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b	Time of 28c. Injury at Injury Work?	28d. Describe how in		
0	endin sath. or: Af he fur	atlo	2 Accident investigation		M 1 ☐ Yes 2 ☐ No	_		
Division of Vital Records,	or Att fler de pirect n by t	Certification;	3 Suicide 6 Could not be determined	 Place of Injury - At home, building, etc. (Specify) 	farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in l		On Continue al Constituing Physics	in a Table base of my brounded			(-)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner	: On the basis of examination and manner stated.	ige, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	red at the time, date a	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		Date signed (Monti	h, Day, Year)
)) Ones		D0062043	Aug	ust 29Th	2005
	(3)		30. Name and address of person who comp	pleted cause of death (Item 23a	a) (Type, Print)	7	Area.	202
	9		31. Date filed (Month, Day, Year)	S > M · D · (200 N. WOLLE ST 1	JuTimore	M) 21	48 t
	Sta Registi		SEP 0 2 200	5 Magaza A	DO002043			
	30			1-00	18			

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Aug. 2005 Sarah Louise Pfeffer 2:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Mayontb Days 5. Social Security Number Birthplace (State or Foreign **Funeral** 1□M 2 F 215-12-7394 Vfrg1nia Director Usual Residence of Decedent the Maryland 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Carroll Hampstead Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 494 Woodsman Dr. Unit 912 21074 U.S.A. 230 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates! W II Items . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other then "neturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 D Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Food Service College (1-4or 5+) Elementary/Secondary (0-12) Owner and Operator Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ss 1 and 2 should be fi of Health and Mental H item 27 is marked oti George Frank Sine Pauline Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4175 Hanover Pike, Manchester, Md. 21102 Martin K.P. Hill - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Himportent: If ite eny injury or ot once. 1 ☐ Burial 2 II Cremation 3 ☐ Removal from State Metro Crematory Sept. 3,2005 Baltimore, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RIGHT INTRAPARENCHYMAL 6 HOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent oregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown COUMADIN THERAPY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 □ No ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FELL IN BATHROOM 1 ☐ Yes 2 No 24 hours after death. P Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4474 WOODSMAN DR HOME HAMPSTED MD 21077 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 To the 29c. License number Poo jiq 2 v 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G-OURISHANKAR MAGANNA POOLE RD WESTMINSTER MD 21157 700A 31. Date filed (Month, Day, Year) 32/Registrar's Signature SEP 0 2 2005 Registrar

		-	For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	artment of F tificate of	lealth and I <i>Death</i>	Mental Hy	giene (05 28780
Dh	voicis	¥	1. Decedent's Name (First, Middle						2. Date of Dea	ath Day	3. Time of Death Year
	ysicia Medic		Anthony Raymor						August	31, 200	
Ex	amin	er	4a. Facility Name (If not institution 1911 Middlebor	-	umber)			r Location of Death SEX	1	4c. County Balti	
Fun Dire	eral ctor		5. Social Security Number 216 54 6797	6. Sex 1 ½ M 2□ F	7. Age (In yrs. 53	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da April 1	y, Year) 3,1952	9. Birthplace (State or Foreign Country) Maryland
- <u>-</u>			Usual Residence of Decedent						11-2		
arylar show	100	_	10a. State 10b. County	mana	10c. C	ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
he M	all la	ecto	Maryland Balti	more			SSEX 10f. Zip Code			10g. Citizen of V	
h with t	at ber	i Dir	1911 Middleboro	ough Rd.			212	21		US	1.400
. I. Z. I. 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show	the Medical Examinar must be nutilised at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2X Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 XYes	cedent Ever in U Forces? 2		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Rac Blac Specify	e - American Indian, ck, White, etc. y: White
5-UUSD 72 hours aft natural, or	Kal			it's Education		16a, Deced	lent's Usual Occup	pation during most of wor	rkina	16b. Kind of Bu	usiness/Industry
ithin 7	Med Med	Completed	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)	life. I	OO NOT use retire	d)		Di atri bi	ution Company
filed w Hygier Ather ti	H.		12 17. Father's Name (First, Middle,	Last)		3	uperviso:		ne (First, Middle,		
	ic event,	To Be	Anthony Raymond		r Sr.			Verna Ma			
shou	umat	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ırai Route Numbe	er, City or Town,	State, Zip Code)
and 2 sl and 2 sl salth an	er tra		Judith L. Sergo	otick (Si				Avenue 1			yland 21236
Baltimore, Marylan permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked	ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		m State	cemetery, crer	sition (Name of natory or other plain rematory		Date /2005		City or Town, State re, Maryland
Baltimor permit. Pages Department of	any inju once.		21 grundered Funeral Service	the state of the s	In C			ki Funera Eastern <i>A</i>			3. 21221
£.			23a. Part1. Enter the disease, o shock, or heart failure. List	r complication t	caused the dea						Approximate Interval Between
Énysi	cian		Immediate Cause (Final disease or condition	7	1. 12.	tele	Clore	relal	Carce	noma	Onset and Death
/Med Exam			resulting in death)		o (or as a conse	quence of):					
/ bet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due t	o (or as a conse	quence of):					
icate be executed obvision and	the burial-transit	i Exar	that initiated events resulting in death) Last	C. Due	o (or as a conse	quence of):					
cate be exphysician	the b	edicai		d							
SOX of ath certif	or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Liv	outcome of pregree birth 2 Fet Fet Formant at time of known	al death 3[Ectopic pregnance Other (specify)	у			ite of delivery onth Day Year
BCOLDS, P. Claw requires that the as been signed by	be detached f	þ	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause giv	ven in Part I.		obacco use cont Yes 22 No	tribute to the cause of death?
ecords, law requires t	should b	etec							24a. Was		Were autopsy findings available
T e e	96 2	Completed							autor	osy ormed?	prior to completion of cause of death? 1 ☐ Yes 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
VITAL VITAL rector, p	Be C	25. Was case referred to medica examiner?						ath (Check only o	one)		
hye hy	ö	7	1 ☐ Yes 2 🗶 No			ER/Outpatier	IT 3 DOA		Home 5 ₹ Resi		
On C ding F	funera	tion:	27. Manner of Death 1 XNatural 5 Pendi 2 Accident invest	ng (M igation	te of Injury onth, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 ☐No	28d. Describe	how injury occur	red
DIVISION C To the Hospital or Attending Pi within 24 hours after death To the Fineral Director: After the	d in by the	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be 28e. Pla	ice of Injury - At liding, etc. (Spec	home, farm, str hify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	ber or Rural Route Number,
e Hospita 24 hours	etely fille	edical C									anner as stated. and due to the cause(s)
To the	сошь	Me	29b. Signature and title of certific	er /	10		29c. Licens	1	,	29d. Date signe	ed (Month, Day, Year)
	J		Duris	MH	al			20396		Septen	le 2,2005
13	M		30. Name and address of person	tahn	5601	Lock	Print) Raver	- Blud	2 Ba	Homor	e Md 21239
- R	Sta egistr		31. Date filed (Month, Day, Year SEP 0	2 2005	. gegistrar's Sign	nature A	medi				,

			State of Maryland / Department of Certificate o		lental Hygi	ene g. No 2 0 0 5	22721
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Wilbur Piloree)	n, or Location of Death	2. Date of Death Month AUGUST	Day Year 31 2005 4c. County of Death	3. Time of Death
	Examir Funeral Director	er	5. Social Security Number 6. Sex 102 M 20 F 80 Yrs. 124 M 30 8073 102 M 20 F 80 Yrs.	Sa hma	8. Date of Birth (Month, Day, Oct. 28	N/A	place (State or Foreign ntry) th Carolina
	g	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		000. 20		10d. Inside City Limits
	ath with the 23e or 286	rai Direc	10e. Street and Number 2711 Huron Street 2	21230		g. Citizen of What Cour U.S.	
036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Iteme 23e or 28e-f show ent, the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	of Hispanic Origin? (Spi uban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho ene. then "natur ha Medical	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret) Truck Drive	ne during most of work ired)	ing	6b. Kind of Business/In	·
yland 2	should be filed and Mental Hygi s marked other umetic event, I	To Be C	John Robert Pilgreen	Elle	e (First, Middle, Me en Avery		
	1 and 2 sho Health and em 27 is m ther treum		19a. Informant's Name/Relationship (Type, Print) Margot Pilgreen / wife 20a. Method of Disposition 19b. Mailing Address (Stre	Street Ba	ltimore,	City or Town, State, Zip Maryland 2 Oc. Location - City or To	21230
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or iteme 23e or 28e-f ehow any injury or other treumetic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Cemetery, crematory or other p Holy Cross Cemet	clace) cery 9/3/ dress of Facility G	2005 once Fune	Baltimore, eral Servic imore, Mary	Maryland e, P.A.
68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	itus	or respiratory arres	st,	Approximate Interval Between Onset and Death VEWS YEAV YEAV
P.O. Box 6	the death certifi y the attending sched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	ery Day Year
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The part of the pa	Mary	12 shound Min and Min	-	19a. Informant's Name/Relationship (Tyr. Print) (SISTOR) 19b. Mailing Addres	ss (Street and Number or Rural R	oute Number, City	or Town, State, Zip	Code)
Physician / Medical Examiner 238. Part / Erier the/fisses, or complications ther/caused the death. Do not enter the mode of tyling, such as cardiacy or respiratory arrest, strong or heart fishure. List only one cause on each time. The mode of tyling, such as cardiacy or respiratory arrest, strong or heart fishure. List only one cause on each time. The mode of tyling, such as cardiacy or respiratory arrest. Approximate and constitution or cause of mean time. Approximate and constitution or cause on each time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or cause of mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constitution or mean time. Approximate and constituti		ss 1 and of Healt itsm 2 r other t		cemetery, crematory or	ame of pate other place)	200. 1	Location - City or To	An, State
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA AKIN MO VAMC, IO N. Ercene St, Balthmark 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	0	es De De	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.			
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State of Maryland / Department of Health and Mental Hygic Amend Items 23a, b, 25, 27, 28a-f. per ME, G847.09/01/05dhb 28783 1 - For State Registrer Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician VIRGINIA 705 RENFRO 25 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BEDERD COURT Silver Spains Silver Montgoner 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar 23, 19 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days Months Hours Min 10 M 25 F Yrs. Director 214-12-3214 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits rel', or Items 23s or 28e-f show Examiner outst be notified at 1 Yes 2 No Director Rockville 10f. Zip Code MD Montgomery 10g. Citizen of What Country? 145 Carrollton Road 20853 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry un k unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Homer Thayer Eleanor Kathryn Mosser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n any injury or other treun Beth Turner/daughter 12406 Linganore Ridge Drive Monrovia, MD 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ∑Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Part : Enter the disease, or complications that bedsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or consition resulting in death) Physician Myo CARDIAC INFARETION Due to jo as a consequence of): /Medical Examiner Hypertensive Atherosclerotic Cardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Disease CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIP FRACTURE 2 No 3 Probably 4 Unknown Completed FIBALIATION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was clash referred to medical examiner? 1 Yes To the Hospitel or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 X No Subject fell Accident 07/12/2005 Unknown 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 14519 Carrollton 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home determined 4 Homicide Road, Rockville,MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)18726 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

ARTHUR SCHOENGOLD, MD 3700 INTERNATIONAL DRIVE SILVEN Spring, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 1 2005 Consider Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28784 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** Month Year 080C M 29 Zoos /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** cheverly pita rge's 6 1505 Toge 5 If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 298-78-692 Yrs. Director 6-27-80 Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits 28a-f show or other treumatic event, the Medical Examiner must be nutified at 1 Yes 2 No Director exandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or Kd. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filad within 72 hours aftar nent of Health and Mentai Hygiene. int: If item 27 Is markad other than "naturel", or Ite 1 □ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 161 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth 19a. Informant's Name/Relationship (Type, Prir 19b. Mailing Add Lss (Sty.-t and Number or Rural Route Number, City or Town, Late, Zip Code, Lother .00 don/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Importent: If any injury or once. 21. Signature of Funeral Service Licens as ne Junera 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) MoTor Vehicle Accident with Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disa to for sels nonecourance off ate has been signad by the attending physician and page 2 should ba detached for use as the burial-transit The law requires that the death certificata be exacuted Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 20 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examina?
1. ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 435/ 400/100 5 Pending investigation 1 Natural vehicle struck Thee 1425 1 ☐ Yes 2 ☑ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

City or Town, State)

As Fund Route Number, City or Town, State)

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28f 6 ☐ Could not be 3 Suicide 4 Homicide 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 140055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

			1 - For State Registrar		artment of Health and Martificate of Death		ene 2005 28785
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year 3. Time of Death
	Physici /Medio		LEONARD LEE RINGO	GOLD SR.		AUGUST	3 2005 835 AM
	Examir		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death		4c. County of Death
			1421 CHARLESTOWN DRIV	7E K	EDGEWOOD If Under 1 Year If Under 24 Hrs.	8. Date of Birth	HARFORD CO
	Funeral Director		215-56-4024		Months Days Hours Min.	(Month, Day, Y	
	ס		Usual Residence of Decedent			MARCH 26	
	anylan show	<u>.</u>	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Pe M	ecto	MARYLAND HARFORD	CO EDGE	WOOD 10f. Zip Code	10-	
	with with the or 3	늅	10e. Street and Number 1421 CHARLESTOWN DE	אדעה ע	21040	109	p. Citizen of What Country? U.S.A.
	ns 23	era	11 Marital Status 12. W	as Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, it is M. diral Exciptational conference on the Defined at Once.	by Funeral Director	1 Never Married 2 Married 1	Yes 2 K No	lf Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2XXIIIo <i>Specify:</i>	Rican, etc.)	Black, White, etc. Specify: BLACK
21215-0036	2 hou atura	ted	15. Decedent's Education		dent's Usual Occupation	16	b. Kind of Business/Industry
215	thin 7 e.	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	pleted) (Give life. ollege (1-4or 5+)	kind of work done during most of worl DO NOT use retired)	ang	
7	ed wi	Cou	12th grade	CHI	LDCARE		HILDHOOD DEVELOPEMENT
ind	be fill d off	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	iden Sumame)
3	hould d Mer marke matic	L _O	JAMES MADDOX 19a. Informant's Name/Relationship (Type, P.	rint) 19h Mailie	ng Address (Street and Number or Ru	MADDOX	City or Town State Zin Code)
Maryland	id 2 s Ith an 27 Is i		Nancy A. Ringgold/Wi		Charlestown Dr.		
ē,	s 1 ar		20a. Method of Disposition	20b. Place of Dispo			c. Location - City or Town, State
9	Pages ent of nt: If i		XXBurial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State		02-05 M	IDDLE RIVER, MARYLANI
Baltimore,	permit. Departmitmortal		21. Signatura Funeral Server Licensee	WI WI	2. Name and Address of Facility LLIAM C BROWN COM	MUNITY FU	NERAL HOME P.A.
			23a. Part1. Enter the disease, or complication	is that caused the death. Do not ent			BERDEEN, MD 21001 Approximate Interval Between
	Priysician	e di	shock, or heart failure. List only one cau Immediate Cause (Final disease or condition		tic Cardinaso	1.1	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	- Contract	more a	Meline
	Lxammer	r.	Sequentially list conditions, b.	Due to (or as a consequence of):			
	uted J unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
oʻ	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):			
8760,	ate be sysicie	dlcal	d.				
9	artifica ing ph e as ti	Med	IF FEMALE:				
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the de led by the a detached t	hys	9 Unknown 9	Unknown			
	ires tha signed d be der	by	Part II. Other significant conditions contribut Hy 1.0 Census.		nderlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 ☑ Probably 4 □Unknown
Records,	w requir been si should	Completed	7/10000				
Rec	has ge 2 s	ld III				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
a	n: Th ificate or, pa	e Co	25. Was case referred to medical		CC Plans of Poss	performe 1 ☐ Yes 2 Z	No 1 ☐ Yes 2 7 No
Vital	Physicien: r this certific ral director,	To Be	examiner? 1 Ves 2 No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other	h (Check only one)	be 6 Other (Specify)
Division of			i gairtatarar	a. Date of Injury 28b. Time o (Month, Day Year)		28d. Describe how	
visio	Attend er death ector: A by the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
ā	pitel or A urs after srel Directilled in by						
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	edical	(Check only 2 Medical Examiner: C	: To the best of my knowledge, death on the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus	se(s) and manner as stated. and place, and due to the cause(s)
	To I To I	Σ	29b. Signature and title of certifier	(A)	29c. License number	29d	. Date signed (Month, Day, Year)
,	^		Dernayd for the	Me-My DME	4014206	lle	quet 30, 2005
_	<u> </u>		BERNARD J. Kyk	ted cause of death (Item 23a) (Type,	1018 HOLABIRE	AVE I	ENTO Md 21222
	Sta Registi		31. Date filed (Month, Day, Year) 7 SEP 0 2 200	32. Registrar's Signature	Goode		

			1- For Amend Item 8 State of Maryland / Department of Health and I negistramend item #16a PER INF G847 GERMICATE of Death	Mental Hyg	iene	20706
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	6. The of DOth
	/Medic	al	Mary L. Ready 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	August	31, 2005 4c. County of Death	6:35 AM [™]
	Examin	er	Montgomery Hospice Casey House Rockville		Montg	omerv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		5/18/46 9. Birthpla Count	ace (State or Foreign
	Director	-	017-34-4175 59 Yrs.	June 24	, 1946 Mass	achusetts
	ryland how		10a. State 10b. County 10c. City, Town or Location		10	d. Inside City Limits
	Ba-f s	ecto	Maryland Montgomery Bethesda			1 ☐ Yes 2 No
	with t	Funeral Director	10e. Street and Number 10f. Zip Code 20814	'	Og. Citizen of What Count United	
	death	nera	4503 Amherst Lane 20814 11. Marital Status	pecify Yes or No-	14. Race - America Black, White, e	ın Indian,
36	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or Itams 23a or 28a-f show avent, Ita Medical Examinating mat be mailfied at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:	o riloan, olo.)	Specify:	
21215-0036	hour	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Indi	White
215	within 72 ene. than "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use natired) REGISTERED NURSE	rking		
2	e filed wil at Hygien othar th vent, the		2 <u>Licensed Practical No</u>	me (First, Middle, I	Health	Care
anc	d be fi	o Be			Thiffault	
Maryland	ges 1 and 2 should be it of Health and Menta it itam 27 is marked or other traumatic av	^L	William Ward 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Ru</i>			Code)
	1 and 2 Health a tam 27 is		James M. Ready/ Husband 4503 Amherst Lane Be			
altimore,	tges 1 au nt of Hea : If itam or othe			tember	20c. Location - City or Tov	
Ħ	permit. Pages 1 Department of H Important: If its any injury or ot		1. Signature of Fur al Service Licensee / Crematorium Inc. 5,	2005 <u> </u>	<u>Bethesda, N</u> Pumphrev Fund	eral Home/
Ba	Departing any ir		Bethesda-Chevy Chas Bethesda, Maryland	se Inc. 20814-35	7557 Wiscons	sin Avenué
			23a. Part1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer			Onsot and Boatin
	Examiner		Due to (or as a consequence of):			
	p ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			
V	be executed ician and burial-transit	Examiner	Cause (Disease or iffury) that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed obysician and the burial-transit		d —			
9	death certificate e attending phys id for use as the	Physician/Medical	IF FEMALE.			
Вох	eath certific attending pl	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliver	y Day Year
0	의 보다	ysic	1 Yes 2 No 9 Unknown 5 Other (specify)			
۳,	requires that the sen signed by nould be detact	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribute to the	cause of death?
ord	w require been sig should b			1 🗆 Ye	es 2⊠No 3⊟Proba	bly 4 □Unknown
Vital Records,	aw as b 2 sl	Completed	\	24a. Was a autops	y prior to com	sy findings available pletion of cause of
la		e Co	25. Was case referred to medical 26. Place of Dec	perform 1 ☐ Yes 2 ath (Check only on		2□ No
f Vi	ys is	To B	examiner?		ence 6 XOther (Specify)	Hospice
n of			27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 Natural 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Division	tan deatl tor: the	ficat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (St	reet and Number or Rural	Route Number,
Ö	in the	Certification:	4 Homicide building, etc. (Specily)	City or Towr	n, State)	
	호드 늘 중	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examiner and the basis of e	e, and due to the caurred at the time, d	ause(s) and manner as sta ate and place, and due to	ted. the cause(s)
	To tha h within 24 To tha F	M	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month, D	ay, Year)
F	N		D35635		August 3	1, 2005
	\ "		30. Name and address of promotes of promotes of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road Rockville	e. Marvls	and 20855	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 9 1141 Y 16		
	Registr	ar	31. Date filed (Month, Day, Year) SEP 0 2 2005			

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 0

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760;

32. Redistrar's Signature

RESIS

2 2005

	-	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20							005	28788	
Physician /Medica	1	Decedent's Name (First, Middle, Last, DOROTHY Facility Name (If not institution give)			OTHST		2. Date of De Month	Day	Year 2005 hty of Death	3. Time of Death 245 PM	
Examine				n yrs. last birthday)	4b. City, Town, or Location of Death B2 1 + Cit If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Hrs. 8. Date of Bir	th		N/A lace (State or Foreign	
Rothstein Renaise must be notified at the medical Evaluation of the me		Usual Residence of Decedent 10a. State 10b. County	10	90 Yrs. Oc. City, Town or Lo	cation			,1915		NY Od. Inside City Limits	
	Director	MD BALTIMORE 10e. Street and Number 8503 TOPPING ROAD			10f. Zip	BALTI Code 21208	MORE	10g. Citizen o	f What Coun	,	
of the felical Francisco in 72 hours after death w n "natural", or items 23a fed deal Estrainer mutth	by Funeral	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	ir in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto			? (Specify Yes or No uerto Rican, etc.)	r No-) 14. Race - American Indian, Black, White, etc. Specify: WHITE				
21215-0036 d within 72 hours at giene. It has "natural, or the Wedden Eram	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ECCRETARY			16b. Kind of Business/Industry STATE OF NEW YORK			
d 2 Hygi	lo ge Co	17. Father's Name (First, Middle, Last)						(First, Middle, Maiden Sumame)			
C= N L		20a. Method of Disposition	GRANDSON		TOPP	(Street and Number of			1208		
Baltimore, permit. Pages 1 at Department of Hea Important: if item ent injury or othe ance.		1 Burial 2 Cremation 3 A 5 4 Donation 5 Other (Specify) 21. Sign fure of Funeral Service License	H	HOUSE OF C	JACOB . Name an	CEMETERY Set Address of Facility	SOL LEVIN		ROS.,	INC.	
	LYB	23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) a. Acute wyocadial infaction Due to (or as a consequence of): Advial Fibrilation Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):									
	Dy Filysicialiymedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
	ed by ri	Part II. Other significant conditions contributing to death but not resulting in the unde							tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
f Vital Record system: The law requir is certificate has been s director, page 2 should							24a. Was autor perfo 1 Yes		prior to com death?	sy findings available apletion of cause of	
Vita	1	25. Was case referred to medical examiner? 1 Yes 2 No									
on of \ding Physi h. After this c funeral dire	1	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d.						dence 6 ∐OI			
Division c	ci micano	Injury Work? Injury Work? Injury Work? Injury Work? Injury Work? Injury Work? Injury Work? Injury					28f. Location (S	28f. Location (Street and Number or Rural Route Number. City or Town, State)			
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	בפונים	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
1) L 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29b. Signature and all less of lesson who are	Amo	Mary 22 to 199	\mathcal{D}	63298		29d. Date signed (Month, Day, Year) August 31, 2005			
State Registrar		30. Name and a thress of person who con the North State (Month, Day, Year) SEP 0. 2. 2005				ipital of B	oltimore	٠			

				State of Maryland / Department of Health and 1- State Amend Items 25,28a-f per ME,G846,08/26/05dhb. 1- State of Maryland / Department of Health and 1- State of Meryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health and 1- State of Maryland / Department of Health / Department / Depa	Mental Hy 3-05 tas	giene	005	28789
		D		1. Decedent's Name (First, Middle, Last)	2. Date of D	eath Day	Year	3. Time of Death
		Physici: /Medic		Helen F. Sheingorn	2. Date of De Month 28 July 28	29 , 200)5	7:35 P M
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec	ath	4c. Cour	nty of Death	
		Europal		Suburban Hospital Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi			gomer 9. Birth	y place (State or Foreign ntry)
		Funeral Director		100-12-6631 1 M 20 F 86 Yrs. Months Days Hours Min	June 8	ay, Year) • 1919		York
		pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		Manylis f aho	jo	DC Washington				1 XYes 2 □ No
		death with the Maryland ms 23e or 28e-f ahow Limust be notified at	Director	10e. Street and Number 10f. Zip Code		10g. Citizen	of What Cou	ntry?
		23e c	alD	3139 Tennyson Street NW 20015		United		
		er dez İtems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)		lace - Ameri lack, White,	
	336	urs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ XNo If Yes, Give 1 □ Yes 2 □ XNo Specify: Year or Dates:		Spe	city: Whi	te
	2-0	72 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	rorkina	16b. Kind of	Business/Ir	dustry
W	121	ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		0 11		
K	0	filed v Hygie other t		4 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's N	ame (First, Middle	Own Ho		
5	<u>lan</u>	Ald be Alental rked of tic ever	To Be	Joseph Frank Bessi	e Lipsky			
7	Maryland 21215-0036	2 should and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 21, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20				Code)
	6,≥	1 and 1ealth 9m 27 ther tr		William Sheingorn Son 3139 Tennyson St. NW 20a. Method of Disposition 20b. Place of Disposition (Name of	wasning Date	20c. Locatio		own State
OXXCHIM	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic evant, the Medical Examination must be notified at ance.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 1 ★ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Nat. Cemet. Aug		Triang		
2	altir	mit, Poartme		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J				
7	ä	Depar Depar Impoi any ir		Str without Graham 5130 Wisconsin Av	e. NW Wa	shingto	n DC	20016
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
(C		Physician /Medical	ı	Immediate Cause (Final disease or condition resulting in death) a. Intracranial Hemorrhage	7			
3		Examiner		Due to (or as a consequence of):				
7128/06		P. F	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- INER			
119		ecutec and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	ICAL EXAMINE			
	8760,	icate be executed physician and the burial-transit	al E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):				
25	687	ifficate g phys as the	edlcal	CERTIFICA				
1	Вох	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		1	Date of deliv	ery Day Year
N	O. E	the at	yslcl	in the past 12 months? 1 Yes 2 No 9 Unknown 9 U			WORTH	Suy Tour
ORN	Δ.	that the	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use co	ontribute to I	he cause of death?
6	rds	quires tha in signed I uld be det			10	Yes 2□No	3 Pro	bably 4 XUnknown
EIN	Records,	e law requir has been s je 2 should	Completed		24a. Wa	s an 24	prior to co	opsy findings available ompletion of cause of
HE	Ä		Com		perf	ormed? 2 X No	death? 1 ☐ Yes	
\sim	Vital	Physician: The this certificate ral director, pag	Be	examiner? Hospital:	eath (Check only			
17	o		7. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Res 28d. Describe	how injury occ		(V)
×	ion	Attanding Ph r death. actor: After th by the funeral	atlo	2 Accident investigation 7/25/2005 anknown M 1 Yes 2 No	Swimmi	ng		
EI	Division	or Atterdenter de liracton by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Nu own, State)	mber or Rur	al Route Number,
73		ie Hospital or Attandi n 24 hours after death na Funeral Diractor: A bletely filled in by the ft		29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ce, and due to the	cause(s) and	manner as	stated.
H		To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.				
		To the I within 2 To the I complet	ž	29b. Signature and title of certifier 29c. License number		29d. Date sig	ned (Month,	Day, Year)
				1. Xallex Hada 62949		7/20	1105	[17]
				30. Name and a Bross of person wild con pleted cause of death (Iter 23a) (Type, Print) Natasha Haag MD 0000 Old Georgetown Road Bethesda, M	D 20814	,		
		sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
		Regist		AUG 2 6 2005 Mayer				

	ian	1. Decedent's Name (First, Middle, Barry T.	Staton					2. Date of D Month	Day	Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution,	Dillion		4b. City, To	own, or Location	on of Death	August		2005 ounty of Death	1:06 a
	-8	3030 GRANTLEY	AVENUE			LTIMORE				N/A	
uneral			6. Sex 7. Age (In yrs.	Van) If Under 1 Months	Year If Und Days Hour	ter 24 Hrs. S Min.	8. Date of Bi (Month, D	irth ay, Year)		place (State or Fore
irector		217-84-2677 Usual Residence of Decedent	4	1				SEPT	22 196	03 M	ARYLAND
ahow ed at		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation.						10d, Inside City Lim
od other than "natural", or items 23a or 28a-f abov event, the Modical Examinar must be notified at	Director	MARYLAND N/A		BA	LTIMOR						1 X Yes 2 □
P Or	P	10e. Street and Number 3030 GRANTLEY	ATTENITIE		10f. Zip C	1215			10g. Citizer	n of What Cou	intry?
- Lung	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.		nt of Hispanic y Cuban, Mexi	Origin? (Sp	ecify Yes or N		Race - Amer	can Indian,
all la	F	1XXXNever Married 2 ☐ Marrie	Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give		1 Yes 2			Rican, etc.)		Black, White	, etc.
Exp	d by	3 Widowed 4 Divorced	Year or Dates:				y.				ACK
edice	Completed	15. Decedent's (Specify only highest		(Give	edent's Usual e kind of work DO NOT use	done during n	nost of work	ing	16b. Kind	of Business/Ir	ndustry
I se l	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ISABLE				N/	'A	
/ent,	0	17. Father's Name (First, Middle, L.	ast)		TOTIBLE		ther's Name	e (First, Middle			
matic event, the M	To B	WILLIAM STATON	I				FRANCE	ES E FR	EEMAN		
		19a. Informant's Name/Relationshi		19b. Maili	ing Address (Street and Nur	nber or Rura	al Route Numb	ber, City or To	own, State, Zi	p Code)
her tr		Frances Staton/				ntley A		-	_		
		20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation	3 □Removal from State	cemetery, cre	osition (Name ematory or oth	er place)		Date	20c. Locat	tion - City or T	own, State
oliery.		4 Donation 5 Other (Spe	ecity) MT		L CEME		09-2-			LK, MA	
any injury o		21. Signature of Euneral/Service Li	000111111	พื	VILLIAM	Address of Fa C BROV NORTH	NN COM	MUNITY	FUNER	RAL HOM	E P.A.
	1	23a. Part Ent The disease, or c	complications that caused the deat		-						
dical		snock, or heart railure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused the deat inly one cause on each line. a. Due to (orus a consequence)	L C V	mer the mode	of dying, such	as cardiac of	nt respiratory a	Synd	ljome	Approximate Interval Betweer Onset and Death
dical niner	al Examiner	Immediate Cause (Final disease or condition	Acquir.	quence of):	MMUY	u de	ricie	ney.	Synd	lome	Interval Between
ine privial transit	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Acquir.	quence of):	mmun elic ll de	u de	as cardiac of the core	ney.	Synd	lione	Interval Between
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n by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (on as a consequence of the consequence o	ancy al death 3 leath 5 leath	MMUY Compared to the compared	gnancy sity) 26. Pla Other: 4 C. Injury 4 Work? 1 Yes 2	Levert I. ace of Death Nursing Ho	23e. Did 1	tobacco use Yes 2 No one idence 6 how injury of	Month contribute to to the second se	rery Day Year the cause of death bably 4 Dunkno
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State of Maryland / Department of Health and Mental Hygien 200528791 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 28 10:50 A.M Hnn amme /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AI Sel Pla Hartord Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 65 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Har ingdor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 MODE Was Decedent Ev Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Workmans JOHNS HOPKINS Comp. Kep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) onus 1691010hen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type: Print) Holly JR Date, 20c. Location - City or Town, State Knoll 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 9-1-05 rorest Hill EVAIOSFUNERACCHAPTE-21. Signature of Funeral Service Licensee 22. Name and Address of Facility FOREST HILL, MA 21050 EVANS FUNERAL CHAPEL-BELAIR, 3NEWPORT DR 23a. Part I. Enter the disease, or complications that caused the shock, or heart failure/ List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner heratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c y sequence of) Examine the attending physicien and ched for use as the buriat-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 ₩mknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗌 No 1 Yes 2 1NO Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Tes 2 No 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The crititying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/022 8-30-05 nova Kanlende Ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR ACTU. MD 21236, KIWALOUSIG MD 7602 Rel 31. Date filed (Month, Day, Year) GORA 32. Registrar's Signature State SEP 0 2 2005 > Destand Registrar

State of Maryland / Department of Health and Mental Hygien $\stackrel{>}{\sim} 005$

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Stoecker 1.26AM ichard 200 us /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner tosptia If Under 1 Year If Under 24 Hrs. Age (yrs. last birthday) Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10X M 2□ F 59 Yrs 3/27/1946 Director NEW YORK Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Intent of Health and Mental Hyglene. Int: If item 27 I show reked other Hyglene. In a natural; or litems 23e or 28e-1 show any or other treumatic event. It a Maryloa Examiner mans the notities at 10c. City, Town or Location 10d Inside City Limits 10a State 10h County 1 ☐ Yes 2√XNo **Funeral Director** HEDGESVILLE BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25427 USA 2247 MOUNTAIN LAKE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) EDUCATION/WOODWORKING & Elementary/Secondary (0-12) College (1-4or 5+) TEACHER/ARTIST **PHOTOGRAPHY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORIS VINCENT KARL A. STOECKER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) pernit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu 2247 MOUNTAIN LAKE ROAD, HEDGESVILLE, WV 25427 MARIA STOECKER/SPOUSE AUGUST Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X remation 3 ☐ Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 31, 2005 ' 4 ☐ Donation 5 ☐ Other (Specify) BROWN FUNERAL HOME, P.O. BOX 821, 21. Signature of Funeral Service Licenses Maeles m 327 W. KING ST., MARTINSBURG, WV KNOWN 25402 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hypoxemia Five Days Physician /Medical Due to or as a consequence of): **Examiner** Du monal & Die to (or as a conse plance of): embolus Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner The law requires that the death certificate be executed Cholangiocatorioma

Due to (or as a consequence of): that initiated events resulting in death) Last physician a the burial-1 Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ■ No Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 | No Yes To the Hospitel or Attending Physicien: "within 24 hours after death.
To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tyes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 August 29, 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital 600 N. Wolfe St. Bultimore MD 21287 Russell K. Hales The Johns Hopkins 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SFP 0 2 2005

P.0. Records, Vital ŏ

The law requires that the death certificate be executed Box 68760 the use as signed by the a or Attending Physician: Division death. efter deat Director: in by

Physician

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Funeral

Director

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other traumatic event,

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permit. Page Department of Important: if any injury or once.

Physician

/Medical

Examiner

Be Completed by Physician/Medical

To

Certification:

Medical

29a. Certifier

(Check only one)

Examiner

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Pages

Directo

Funeral

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Be Completed

with the Maryland

within 72 hours after death

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Maryland

Baltimore,

AUGUST

within 24 hours e To the Funeral I completely filled

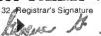
State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 2005



1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1943725

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2005 28794 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 2335 2005 446451 24 SPARROW /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITY BALTIMUNE HOPKINS BAYUZEW If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1√M 2□F Months Hours unk Director 218-60-7609 Mar 3. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28e-f show item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1-√ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA 464 Hornel Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: unk 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nat any injury or other traumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ▼Other (Specify) in state 21. Signal ife of F (2) Service Lts. nsee Ronal 1 S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 nay Wade 236. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Firysician PNEUMONIA 2 WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ INJURY 1 Yes 2 No 3 Probably 4 Unknown ANORTO BRASN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPOYEMIC RES PIRATORY FASLUNE autopsy 28TNo 1 🗌 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Enpatient 2 ER/Outpatient 3 DOA P 1 Yes 28 No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Churlojlen Bylon MEDSCAL DOLTOR QFS-000 AUGUST 24, 200, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 JOHN HUPKINS HOSPITAL CHRISTOPHER INGELMO, THE 600 NORTH WOLFE STREET BATTMORE MANYCAND 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 0 2 2005 Registrar

			1 - For State Registrar	State of Maryl	and / Depa	artment of H	ealth and M Death		gienez 0	05	28795
		1.30	Decedent's Name (First, Middle, Last)			-	2. Date of Dea	ath		3. Time of Death
	Physici /Medic		David Wil	ton	Stewar	+		Month August	30. 20	Year 05	10:20 pm
	Examin		4a. Facility Name (If not institution, give		Decriar		Location of Death	1149400		ty of Death	10,20 pm
¥			212 Margaret Avenu	ie		Essex			Balt	imore	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h		lace (State or Foreign try)
ı.	Director		258-30-6356	79	Yrs.	luionario Dayo	THOUSE TO THE	1/11/	1926	Georg	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10	Od. Inside City Limits
	lanyla sho	5									1 ☐ Yes 2 ☒ No
	28a-1	Director	Maryland Baltimon 10e. Street and Number	<u>:e E</u>	ssex	10f. Zip Code			10g. Citizen of	What Coun	
	with so a			210							.,,.
	leath	era	1 Brett Court Apt	318 12. Was Decedent Ever	in U.S. 13. 1	21221 Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	U. S.	A . ace - America	an Indian,
(0	r Itar	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ack, White, e	etc.
က် ဝ	ral', o	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 X No	Specify:		Speci	ity: Wh:	ite
21215-0036	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	dent's Usual Occupa	ation during most of worki	ina	16b. Kind of I	Business/Ind	lustry
2	lithin Ban 1	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done a DO NOT use retired,)				
7	led w lygier har th	S	8		Repai	rman	40.14.15.1.11.	7000 A B 40-4-47	Gas Pu		
anc	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked othar than "natural", or Itams 23s or 28s-f show afte event, the Medical Exatr har mult be multied at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			me)	
2	should nd Men marke umatic	70	Perry Lugene 19a. Informant's Name/Relationship (7)	Stewart	405 14-10-	ng Address (Street a	Annie	Harre		- 04-1- 70-	2.11
Maryland	01 00 00 =			•					0000		
_	of Health itam 27 i		Nannette Marie Sto		b. Place of Dispo			Essex, N	20c. Location		
no	ages int of t: If if		1 Burial 2 Cremation 3 F		-	natory`or other place	9/4	_	Midal -	. Dd	Mareel and
altimore,	artme ortan injur		21. Signature of Flyaret Septice Linear		22	1 Mem. Ga	s of Facility			: KTvei	r, Maryland
Ba	permit. Pages 1 a Department of He Important: If itam any injury or othe		1		B	ruzdzinsk 407 Old E	i Funeral	Home F	A Geov	Marul:	nd 21221
	Έ,		23a. Parti. Enter the disease, or comp	lications that caused the						-	Approximate Interval Between
	Physician		shock or heart failure. List only o Immediat Cause (Final disease or adition	ne cause on each line.	1.1.	1110	(1)	Onset and Peath
	/Medical		resulting in death)	aDue to (or as a con	nsequence of):	1001	(kn				MUNTRY
	Examiner		Conventially list and distant	b							
7	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):						
V	erute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						16	
8760,	cate be executed physician and the burial-transit		resorting in death) Last	Due to (or as a con	isequence of):						
87	cate be executed physician and the burial-transit	dical		d					-		
9 ×	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as:	/Me	IF FEMALE:	23c. If yes, outcome of pre	egnancy				224 D	ate of deliver	
Вох	atter for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)					Day Year
o.	that the dead by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
s, D	uires that signed b d be deta	by Pł	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to the	e cause of death?
rds	w require been sig should b							De	es 2 No	3 🗌 Probe	ably 4 Unknown
Record	s bee	plet						24a. Was a	an 24b.	Were autop	sy findings available
Ä	The lav	Completed						autop: perfor	sy med? 2 XNo	death?	apletion of cause of
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death				
<u>~</u>	di is	To	1 ☐ Yes 2 XNo	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Resid	ence 6X10t	her (Specify,	Daughters
Division of	ding Ph I. After th funeral		27. Manner of Death 1 ZNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occu	rred	1002/10100
<u>s</u>	ttandin Jeath. tor: Aff the fur	catl	2 Accident investigation 3 Suicide 6 Could not be				/es 2 □No				
<u>></u>	l or At after d Diract J in by	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str oecify)	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rural	Route Number,
	Hospital or Attano 44 hours after death Funaral Diractor: tely filled in by the		29a. Certifier 1 X Certifying Phy	sician: To the best of my	knowledge death	a consumed at the time	a data and along	and due to the d	and m		
	To tha Hospital or Al within 24 hours after o To tha Funaral Dirac completely filled in by	edical	(Check only 2 Medical Exami	iner: On the basis of exame and manner stated.	mination and/or in	estigation, in my op	pinion, death occurr	ed at the time, o	late and place,	, and due to	the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signe	ed (Month, C	Day, Year)
}	, ,,,,,		1 Jan Fal	n.n		DUV	32392		831	10 5	
	1		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Deine		1 3 . 1 7	0		
	2		Gan bric	gan!	245	EHSK	ERN B	MLVd	BAL	to h	1021221
	Sta		31. Date filed (Month, Day, Year) SEP 0 2 2	32. Redistrar's S	ignature	houts >					
	Registr	ar	SEFUAZ	005 Mesure	1 15 /4	The state of the s					

			For State	State of Ma		artment of Hea		ental Hygie	ene	
			Registrar 1. Decedent's Name (First, Middle, La	st)	Ce	rtificate of De	eatri	2. Date of Death	·No. 2005	3. Zim of Death
	Physici /Medic		David	Sykes				August-	Day Year 29 2005	5 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Lo	ocation of Death	hun	4c. County of Death	
	Formul		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under Year	TMORE V	8. Date of Birth	9. Birtho	place (State or Foreign
	Funeral Director		220-36-0717	M 2□F	65 Yrs.	Months Days	Hours Min.	8. Date of Birth	Cour	M)
	and w		Usuel Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Maryl a-f sho	tor	MD Bal	timore	Kand	ellstown				1 🗆 Yes 2 🖂 🗸
	or 28	Dire	10e. Street and Number	10		10f. Zip Code	フマ	10g	Citizen of What Cour	ntry?
	leath v	Funeral Director	8439 HIRASWI	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban,	33 anic Origin? (Spe	cify Yes or No-	14. Race - Americ	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic event, the Modical Examiliar class to multified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 N 1 Yes, Give Year or Dates:	lo	_ \	Mexican, Puerto I Specify:	Rićan, etc.)	Specify: Black	ick
Maryland 21215-0036	72 hor	Completed	15. Decedent's English (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done duri DO NOT use retired)	on ing most of working	ng 16	b. Kind of Business/In	dustry
7	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+) Line		<u></u>	G	eneral 1	Notors
<u>م</u>	be filed ital Hygi d other	BeC	17 Pather's Name (First, Middle, Last,				3. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>ylaı</u>	should b ind Ments marked umatic e	2	Keuthard Sy	Kes		(3 lady	15 Bu	utler	
ă S	and 2 sh ealth and n 27 Is n	,	Pa. Informant's Name/Relations	Type, Print)	\$43	ng Address (Street and	Number of Hura	J. Kund	city or Town, State, Zip	MD 21/32
J.	of Heal		20a. Method of Disposition	December Char	20b. Place of Dispo	esition (Name of matory or other place)		ate 20	c. Location - City or To	own, State
altimore,	Pages Iment of it tant: If it		1	y)	Garrison	n forest	4/7	105 0	Wagniu	ls, MD
Ball	permit. Departr Imports any inje		21. Signature on Fune pol Servicer Licen	Gleene	22	8728 L.b	erty Rd	e fanera . Kandal	L Services Listown, IND	21133
			23a. Part1. Enter the disease, or com shock, or heart ailure. List only	plications that caused one cause on each lin	the death. Do not en	er the mode of dying, s	such a cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CORU	a consequence 1):	ARTIERU	Dis	EASE		=10 YEARS
	Examiner		Constitution and the second	b.	a consequence (4).					
-	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):					
٧.	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):					
8760,<	cate be executed physician and the burial-transit	dical E		_ d						
9		Med	IF FEMALE:	00 - 14						
80	es that the death cerifii igned by the attending I be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Ŏ.	t the d by the lached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Division of Vital Records, P.O. Box	To the Hospitel or Attending Physicien: The law requires that the death certifi within 24 hours after death. To the Funerel Director: Atler this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions			nderlying cause given	in Part I.		cco use contribute to th	
ord	w requir been si should	Completed	HYPEIX	TEN SION	V					
Bec	he faw e has age 2 s	jumo						24a. Was an autopsy performe	d? death?	psy findings available impletion of cause of
<u>ta</u>	ucien: The lav certificate has rector, page 2	Be C	25. Was case referred to medical examiner?			2	6. Place of Death	(Check only one)	No 1 □ Yes	2 140
> o	Physic this ce al dire	은	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatier			ne 5 🗆 Residence	be 6 Other (Specify	y)
ono	ding I th. : Alter : funer	Certification:	1 Actident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) Zab. Time o	Work?	s 2 □No	od. Describe now	illiary occurred	
Visi	Atten er dea rector by the	tifica	3 Suicide 6 Could not be determined	e gen Plans of Inju	ury - At home, farm, str c. (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,
ō	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page		and the state of t	1			1		()	
	s Hosp 24 ho e Func etely f	edical			examination and/or in				se(s) and manner as st and place, and due to	
	To the within To the compl	Me	29b. Signature and title of certifier			29c. License n			Date signed (Month,	1
			Nove				60378	5	08/31,	105
	1		30. Name and address of person who	completed cause of de		Print) FRANKFO	RD AV	ENUF	BALTIMO	RE MD 2120
	Sta		31. Date filed (Month, Day, Year)	32. Bell	r's Signature			- Com		
DI	Regist	-	SEP 02	2000	w & A	TO VE	-			

			,	1 - For State Registrar	State	of Maryla		artment ertificate			Mental H	ygiene Reg. No.	2005	2879	37
		Dharisis		1. Decedent's Name (First, Middle	, Last)						2. Date of D	eath Day	Year	3. Time of Deat	h
		Physicia /Medic		Twila		D.		Simp	son		Augus	t 27,	2005	6:30p	М
		Examin		4a. Fecility Name (If not institution,	-			4b. City,	Fown, o	r Location of De	eath		County of Deat		
				Greater Baltim			nter rs. last birthda	Tows		If Under 24 H	Irs. 8. Date of B		altimor	e	niam.
		Funeral Director		5. Social Security Number 220–82–9531	6. Sex 1 □ M 2 🛛 F	7. Age (in yi	Yrs.	Months			in. (Month, I	lirth Day, Year)	9. Bit	hplace (State or Fore untry) Md.	agn
				Usual Residence of Decedent		-1-1					10-3	-00			
		how		10a. State 10b. County		10c.	City, Town or							10d. Inside City Lin	
		Ba-f s	cto	Md. N	A 			imore						1. Yes 2□	NO .
		with the Maryland a or 28a-f show Le notified at	Dire	10e. Street and Number				10f. Zip		220		10g. Citi:	zen of What Co USA	untry?	
		s 23a	ral	2031 Griffis A		edent Ever in	110 112	Was Decad		.230	/Specific Ves or N	lo. I	14. Race - Ame	rican Indian	
2		ter de	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marri	Armed F	orces?	0.5.				(Specify Yes or Nerto Rican, etc.)		Black, White	e, etc.	
-	980	urs af	by	3 Widowed 4 Divorced	If Yes, G Year or	2F No live Dates:		1 ☐ Yes	No DX	Specify:			Specify: I	Black	
13	5-0036	be filed within 72 hours after death tall Hyginal attains 23 dothar than "natural", or Itams 23 evant, the Madical Examitrations	Completed	15. Decedent (Specify only highes)	16a. Dec	edent's Usua	l Occup	ation during most of	workina	18b. Kir	nd of Business/		
-	2121	ithin ne.	nple	Elementary/Secondary (0-12)	T	(1-4or 5+)	1		e retired	during most of d)		ם אור פו	ını imore	er Harbo Marriott	-
1	121	led w lygier har th		11th grade 17. Father's Name (First, Middle, 1	(act)		Co	ok		18 Mother's	Name (First, Midd			Marriocc	
5	Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "I reaumatic evant, I'm Max	Be	James	W .		Jacks	on		Haze	_	o, maidon	You	ng	
nos	<u>Z</u>	should nd Me mark matic	T _o	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Ma	iling Address	(Street	and Number or	Rural Route Num	ber, City or	r Town, State, 2	Zip Code)	
0	Σ S	and 2 sealth ar n 27 is nar trau		Everett Simpso	n Hı	ısband	20	31 Gr	iffis	Avenu	e, Balti	more,	Md.	21230	
\leq	ore,	s 1 a of Hea itam itam		20a. Method of Disposition	0 C D	205	. Place of Dis	position (Nan ematory or o	ne of ther plac	ce)	Date	20c. Lo	cation - City or	Town, State	
_	altimore,	Pages nent of i		1 Burial 2 □ Cremation 1 Donation 5 □ Other (Sp		State	Cedar				2–05	Ar	nne Aru	ındel Co.	, 1
∨)	Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. Patural, or Itams 23a or 28a-f show proprent: Itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic evant, the Madical Examinet mast be midified at once.		21. Signature of Funeral Service I	icensee u	o an	احم	22. Name an March		ss of Facility .H. Eas			e, Md. North	21202 Ave.	
				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the de	eath. Do not e	nter the mod	e of dyir	ng, such as care	diac or respiratory	arrest,		Approximate Interval Between	
		Physician		Immediate Cause (Final disease or condition		hypo	XP.MI	n						Onset and Death	ı
		/Medical Examiner		resulting in death)	Due to	(or as a cons	sequence of):		(0	1				
		Lxammer	_	Sequentially list conditions,	b	uaul	+ re	Spira	tor	y dis	tress				
		ed sit	Examlner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10	00 45	- O	1000	1	+101	pneun	100			
		be executed sician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to	o (or as a cons	sequence of):	11 010		1 Ia I	Prieur	10/11	a		
	P.O. Box 68760	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical		d										
	9	tificat ng phy as th	ledi		1										
	XO	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pre		B⊟Ectopic pr	egnancy	y		2	23d. Date of del Month	ivery Day Year	
	Э. В	e deal	sicia	in the past 12 months? 1 Yes 2. No		gnant at time o		Other (sp					MORE	Day rear	
	P.0	w requires that the de been signed by the should be detached	Phy	9 Unknown Part II. Other significant condition	ns contributing to	death but not	regulting in the	underlying c	ause an	ren in Part I	23a Dir	1 tobacco u	se contribute to	the cause of death	?
	Š	ires the signer signer the contract the cont	i by	beancha	DIPUCA	1 +	ictul	Os.	auso giv	rom in r unt i.				obably 4 Unkno	
	O.C.	requipe v	etec	Conche	Prince		13140				24a. Wt		24h Woro au	stoney findings avails	able
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	<u>a</u>		e Co	25. Was case referred to medical	C Sh	OCK_				26 Place of	1 ☐ Yes Death (Check only		1 🗆 Yes	2 No	
	5	Physician: this certific ral director,	o B	examiner?	Hoonital: 1	Inpatient 2	P ☐ ER/Outpat	ient 3□ DC	A Cth	0.00	g Home 5 ☐ Re		6 □Other (Spe	cify)	
	Jo (ding Phy h. After thi funeral c	T:U	27. Manner of Death	28a. Dat	e of Injury onth, Day Year	28b. Time		8c. Inju		28d. Describ			,	
	ior	ath. or: Aft	atlo	1 Natural 5 Pendin 2 Accident investig	jation	mi bay roa	/ "' "	М		Yes 2 □ No					
	Division of Vital Records,	r Atta er de recto recto	Certification;	3 Suicide 6 Could reduced determined	not be ined 28e. Plac buil	ce of Injury - A ding, etc. (Spe	t home, farm,	street, factory	, office		28f. Location City or 7	(Street and own, State)	d Number or Ru)	ıral Route Number,	
		urs aff										-			
		To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certification and application to the funeral director.	edical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the Examiner: On the and ma	ne best of my l basis of exam Inner stated.	knowledge, de iination and/or	ath occurred investigation	at the til	me, date and pl opinion, death o	ace, and due to th ccurred at the tim	e, date and	and manner as place, and due	s stated. to the cause(s)	
8		ro the within ro the compli	Me	29b. Signature and title of certifie		^		290	. Licens	se number		29d. Dat	e signed (Mont	h, Day, Year)	
		n _		mark 1	mole	1, 1	UD	1	000	05808	12	8	129/	05-	
	1	10	2	30. Name and address of person	who completed ca	use of death (Item 23a) (Typ	e, Print)	1	0	C 0 1 1	2 11	1.10	14 to	6
	_	1		Mark Go	osnell,	656	9 N.	Char	185	J+,	6011	avill	ion We	ST 10W	20N
		Sta Registr	a .	31. Date filed (Month, Day, Year)	2 2005 32.	Registrar's Si	gnature & a	A at							
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Ī		1/ Nev 1/2	JU1				9								

			for State Registrar	State of Ma	ii ytanu i		tificate of				eg. No.	
			1. Decedent's Name (First, Middle, Las	st)					2.	Date of Deat	h	3. Time of Death
	Physici		Sydney Danielle	Schlobohn	n				A	Month	31, 2005	6:45A M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location		agase .	4c. County of Dea	
	LAGITIII		7400 Arrowood Roa	ad			Bethesd	l n			Montgom	027
	Funeral		5. Social Security Number 6. S		(In yrs. last	birthday)_	If Under 1 Year	If Unde		Date of Birth		rthplace (State or Foreign ountry)
	Director		218-47-1568 1 Usual Residence of Decedent	□м 2]Д] F	9	Yrs.	Months Days	Hours	Min.	(Month, Day, ug. 10	, 1996 Was	hington, DC
	ryland how		10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits
	e Ma	çç	Maryland Montgom	ery	Bethe	esda						1 ☐ Yes 2 No
	rh th or 28	i e	10e. Street and Number				10f. Zip Code			10	0g. Citizen of What C	ountry?
	th wi	<u>a</u>	7400 Arrowood Roa	.d			20817	,			United St.	ates
	dea Fine	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of H Yes, specify Cuba	Hispanic C	rigin? (Specif	y Yes or No-	14. Race - Am	erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "netural", or itame 23a or 28a-f show other traumatic event, the Medical Examiner must be notilised at	by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	0		Yes 2X No			an, etc.)	Black, Whi	nite
Õ	2 hou	ted	15. Decedent's Ed	ucation	1	6a. Decede	ent's Usual Occup	pation			16b. Kind of Business	
218	thin 7	Completed	(Specify only highest gra	College (1-4or 5	F)	life. D	ind of work done O NOT use retired	during mo d)	ost of working			
21	gien gien	5	4			St	tudent	,			Elementary	y School
Maryland	be filed tat Hygid d other	Be (17. Father's Name (First, Middle, Last)					18. Moti	her's Name (F	First, Middle, N	Maiden Sumame)	
/a	should be tind Mental I	2	Cord Schlobohm					Ros	ssana S	San Mar	tin	
an	2 sho and I le ma		19a. Informant's Name/Relationship (7	Type, Print)	1	19b. Mailing	Address (Street	and Num	ber or Rural A	loute Number,	City or Town, State,	Zip Code)
	f and 2 Health tem 27 I		James Kaufman/Fr	iend	7	7514 A	Arrowood	Road	d, Beth	nesda,	Maryland	20817
ē	S 1 S THE TET		20a. Method of Disposition		20b Place	of Disnos	ition (Name of		Date	9 2	20c. Location - City or	Town, State
Ë	Pages nent of I int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Monte	gomer	atory or other place. Im. Inc.	1	Sept. 2005		Bethesda,	Marvland
Baltimore,	글 문란글 .		21. Signature of Funeral Service Licen		Crema	22.	Name and Addre	ss of Fac	lity Robe	ert A.	Pumphrey I	Funeral Home
ñ	Depa Impo any I		1 3 Sund	0	м00803	Bet	thesda-C	hevy Maxw	Chase,	Inc.	7557 Wisco	Funeral Home onsin Avenue
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only			Do not ente	r the mode of dyir	ng, such a	is cardiac or re	espiratory arre	ost,	Approximate
			shock, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)				e Pontin	e G1:	ioma			
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Ž.	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	220 10 (01 22 2		00 017.						
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68760,	tificate be executed ig physiclen and as the burial-transit											
87	cate phys	edical	•	d								
	ding se as		IF FEMALE:	230 If was outcome a	of prognance.							
Вох	eath cert attending for use a	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal dea	ath 3⊟E	Ectopic pregnancy	у			23d. Date of de Month	livery Day Year
	The law requires that the death cer ste hes been signed by the attendir bage 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown	ime of death	1 5∐.	Other (specify)					
P.0	that the de ned by the a detached i	Ph	Part II. Other significant conditions of	antichuting to death but	t not recultin	a in the use	torkina sousa	en in Dest		220 Did tob		- M
	res th	þ	Part II. Other significant conditions of	onthouting to death out	t not resultin	g in the und	deriying cause giv	ren in Pan	· I.		acco use contribute to	
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<u> </u>	The I	ю								perform	ned? death?	
ita	ilcian: Th certificete rector, pag	Be	25. Was case referred to medical					26. Plac	ce of Death (C	heck only one		
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J Of	ding Phy h. After thi funeral o		27. Manner of Death	28a. Date of Injury (Month, Day	Vear) 288	b. Time of Injury	28c. Injur Wor				w injury occurred	
Division	Attending r death. ector: After by the fune	atlo	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigation		(bai)	injury		Yes 2	□No			
<u>vis</u>	l or Attend after death Director: in by the	Ę	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injur	ry - At home.	, farm, stree	et, factory, office		28f.	Location (Str	eet and Number or R	ural Route Number,
Ö	spital or Attenours after deat ours after deat saral Director: filted in by the	Certification;	4 🗆 Homicida	building, etc.	(Specify)					City or Town,	, State)	
	To the Hospital or Al within 24 hours after of To the Funaral Direc completely filled in by	Medical (29a. Certifier Check only anel	ysician: To the best of liner: On the basis of and manner state	examination	dge, death and/or inve	occurred at the tinestigation, in my o	ne, date a	and place, and eath occurred	I due to the ca at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signed (Mont	th, Day, Year)
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	\		30. Name and address of person who				•		1	II Mic	higan Aven	ue, N.W.
			Brian Rood, M.D. 31. Date filed (Month, Day, Year)	Children 32. Registrar			Medical	I Cer	iter W	ashing	ton, D.C.	20010
	Sta Registr			OOF 32. Agistrar	3 Signature	1	a. K. E					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. Nd. 2005 28799 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ERMA Year **Physician** August 8:00 AM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A Harbor Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 25, 1931 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🛛 F 212 30 3360 74 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examinar must be rectified at 1K Yes 2 No Marv1and N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 3556 Horton Avenue 21225 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Environmental Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Mental Robert Lee Sherman Sr. Ruth McNeer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sherman / Nephew 309 - 18th Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 8/30/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. ž 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Little one cause on each line. Immediate Cause (Final disease or condition **Physician** Preumonia resulting in death) /Medical Due to (or as a consequence of): **Examiner** disorde eizure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Diabeles attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3₽Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifue 000 RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harbor Hospital 3001 South Hanover Street, Baltimore, MA, 21225 Bassel Alkhalil, M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Trefuen

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 1400 PM AUGUST SNY DER MARTIN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/31/1925 BALTIMO RE NOR-THEST MOS 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs. PA Director 195-12**-**1067 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28a-f ehow the Medical Exeminar must be notified at 1 ☐ Yes 2 🕅 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 8 POMONA WEST #10 or items 23a by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iten any injury or other traumatic event, it is Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: ARMY 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CONSTRUCTION DESIGNER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) OXMAN SNYDER **JEAN** MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 POMONA WEST #10 - BALTIMORE, MD 21208 RUTH SNYDER / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09/01/2005 WOODLAWN, MD BETH TFILOH CONG. 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physiclan and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year signed by the atte d be detached for Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Onknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 2 No 1 Yes 1 Yes 2 No To the Hospitel or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other 9 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After Injury 1 Natural 5 Pending after death. investigation М 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier win D0059736 no tugual 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD YDRTHWEST HUSPITAL OLD LOURT MD. 5401 DEBURAH 32 Registrar's Signature parket 31. Date filed (Month, Day, Year) State 0 2 2005 Registrar

		State of Maryland / Dep		-	ene.
A 2	es.	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	No.2005 28801
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/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Daltimore (8. Date of Birth	9. Birthplace (State or Foreign
Director		218-26-5014 1 M 2 T 74 Yrs. Usual Residence of Decedent	Months Days Hours Min.	3-2-19	31 mD.
aryland show	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
Sm(th), Aline W re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-1 show other traumatic event, It a Medical Examinating the notitied at	Funeral Director	MD. BALTO. KAND 10e. Street and Number	ALLSTOWN 101. Zip Code	100	1 ☐ HS 2 ☐ No
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Division of Vital Records, to Attending Physicien: The law requires the after death. Director: All properties to the last been signed in by the funeral director, page 2 should be death.		COPD - Chrunia Obstructive	Pulmunary Disease	1 ☐ Yes	2 No 3 Probably 4 Unknown
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funarial Director: Attentia the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deat and manner stated.	th occurred at the time, date and place, twestigation, in my opinion, death occurr	and due to the caus red at the lime, date	e(s) and manner as stated, and place, and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
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3		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 10 Sing: 11	2007-1	ugust 29,2005 f Baltimore
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Registra	a l	Want O to the property of	1		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 005 3. Cimb of Bally 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 1:25 PM M 2005 Tanski 30. /Medical Gloria August 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Genesis Eldercare Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer, **Funeral** 1 M 2 F Director 217-20-3485 77 4, 1928 Maryland Mar. Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f ehow any injury or other treumatic event, the Madical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 726 214th Street 21122 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Senior Auditor I.R.S. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Thomas Mary G. Sortino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Denise E. Adcock (Daughter) 1994 Poplar Ridge Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 9/2/05 Elkridge, Maryland 21. Signature of Fungral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 who 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Duy to (or as a consequence of): mumeria /Medical Du Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last consequence of) Examiner physician and the burial-transit menia Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown for Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sign page 2 should be 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2.2 No certificate has 1 Yes 2 No 1 ☐ Yes I or Attending Phyelcien: after death. Director: After this certifica Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 🗖 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel or within 24 hours aft To the Funerel Di completely filled in 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) alen Burnie MU 21061 Ua 11 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2 2005 Registrar

			1- State of Maryland State of Maryland		artment of He			ene 2005	28803
	Physici		1. Decedent's Name (First, Middle, Last) MARYLAND TAC	KETT			2. Date of Death Month August 3	Dav Year	3. Time of Death 7:00 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Harbor Hospital		4b. City, Town, or L Baltimo	ocation of Death	nugus c o	4c. County of Death	7.00 1
	Funeral Director		5. Social Security Number 407-22-2802 6. Sex 1XI M 2 F 7. Age (In yrs. In 170 M 2 F 79	ast birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	place (State or Foreign ntry) ntucky
	faryland show	ក់ !		, Town or Lo					0d. Inside City Limits 1 ☐ Yes 2 🎇 No
	with the A	Direc	10e. Street and Number 756 01d Riverside Roa		10f. Zip Code 21225		100	g. Citizen of What Cour	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If Item 271s marked other then "naturel", or Items 23a or 28e-f show or other treumatic event, The Medical Examitmer must be notified at	by Funeral	11. Marital Status 1 □ Never Married	S. 13. V	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	within 72 hou ane. then "nature	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give . life. [dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ing 16	b. Kind of Business/Inc	
Maryland 2	should be filed and Mental Hygie marked other imarked other imatic event, III	To Be Co	17. Father's Name (First, Middle, Last) Milton Tackett	Bus	Driver	8. Mother's Name	a (First, Middle, Ma	MTA iden Sumame)	
_	and 2 shoulealth and Mm 27 Is mail		19a. Informant's Name/Relationship (Type, Print) Cleo Tackett (Wife)		g Address (Street an	d Number or Rura	al Route Number, C	City or Town, State, Zip	Code)
altimore,	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other to once.		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ace of Dispos emetery, crem	sition (Name of natory or other place) Cemetery	C	Date 20	c. Location - City or To	wn, State
Balt	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Servic Licensee Kevin E Ecke	r Mc	Name and Address Cully-Poly 7 E. Patar	of Facility Vniak Full	neral Hom	ie. P.A.	225-1856
-	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Que to (or as a consequ	M.	or the mode of dying,	such as cardiac o	r respiratory arrest	CCTION.	Approximate Interval Between Onset and Death
, 90,	cate be executed physician and ithe burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	- 15	HRTER	ES /	ISEAS VELLI	TUS	
.O. Box 68/60	death certifi e attending id for use as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown d. 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
ecords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not result	lting in the un	iderlying cause given	in Part I.		co use contribute to th	e cause of death? ably 4 DUnknown
r	The law ate has b page 2 si	Completed					24a. Was an autopsy performed	d? death?	psy findings available inpletion of cause of
Division of Vital	Attending Physiclen: The redeath. ector: After this certificate by the funeral director, pag	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ER/Outpatient 28b. Time of Injury	Other: 28c. Injury a: Work? M 1 \(\text{Ye}.	4 Nursing Hont t 2 s 2 No	28d. Describe how		
2	pltel or A		4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my know)			City or Town, S		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	on and/or inv	estigation, in my opin	ion, death occurre	ed at the time, date	and place, and due to Date signed (Month, L	the cause(s)
L	11		30. Name and address of person who completed cause of death (Item)	23a) (Type F	D4;	3623	3	3/31/05	>
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	7711	Quarters	mild Ro	Glen	Burnie M.	D 2104
	3.0."		SEP 0 2 2005	Gas	(Ca)				

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 28804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer **Physician** Faul S Varnel1 August 28. 2005 6: 25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare LaPlata Charles 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 15 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1√M 2□ F 579-03 6084 Director Mary Tand Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23s or 28e-f show other treumetic event, the Madical Examinar in ust be notified at 1 Yes 2 No Director Maryland Charles LaPlata 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code U.S.A. 20646 #1 Magnolia Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ð Specify: White 3 Widowed 4 Divorced 1947 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than D.C. Taxi Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumetic event Be Eva Rozier Ν. Varnel1 Andre 19a. Informant's Name/Relationship (Type, Print)
Dana Marie Ernst (Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13264 Harry Berry Lane King George, VA 22485 20b. Place of Disposition (Name of cemetery, crematory or other place) September 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 2005 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) Lee Funeral Heme, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DUC 6633 Old Alexandria Ferry RD Clinotn, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20101 an /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai nse : IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Munknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 🖾 No this certificate or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation death. 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medicet Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Ukoh, MD 4404 Queensbury Rd. #110 Riverdale. Md 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma	-	•	t of Health ai e of Death	nd Mental H	ygiene Reg. No 20	05	28805
45	Physici	an	1. Decedent's Name (First, Mide					2. Date of D	leath Day	Year	3. Time of Death
	/Medic	al	Dorothy Vaug			4b. City.	Town, or Location of	Death Flucy	4c. County	ot Death	10:41, W
	Examin	ier	Social Security Number	Genera)	e (In yrs. last birth	a) If Under	1 Year If Under 2	4 Hrs. 8. Date of B	irth	9. Birthp	place (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. Count	by	10c. City, Town	or Location				1	0d. Inside City Limits
	death with the Maryland me 23a or 28a-f show f must be notified at	tor	MD		Baltim	ore					1∭ Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip			10g. Citizen of V		itry?
	e 23a	rai	3600 W. Frank	lin Street #E		12 Was Door	21229	in? (Specify Ves or N		USA e - Americ	can Indian,
38	within 72 hours after death with the Maryla ane then "natural", or Itame 23a or 28a-f ehov is Mudical Extrining must be notilled at	by Funerai	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Forces? 1 Yes 2		If Yes, spe	dent of Hispanic Origicity Cuban, Mexican, 2 No Specify:	Puerto Rican, etc.)		k, White,	etc.
2-00	72 hou natura	eted	15. Decede	ent's Education lest grade completed)	16a.		rk done during most	of working unk	16b. Kind of Bu	ısiness/Inc	dustry unk
121	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. DO NOT u	se retired)				
and 2	permit. Pages 1 and 2 should be filed withir Depertment of Health and Mental Hygiene. Important: If item 27 le marked other then eny injury or other treumatic event, It a M. 2010e.	Be	17. Father's Name (First, Middle		1		unk 18. Mother	's Name (First, Midd	le, Maiden Sumam	Θ)	unk
aryl	2 should and Men le marke eumatic	ဥ	19a. Informant's Name/Relation	nship (Type, Print)	19b.	Mailing Address	(Street and Number	or Rural Route Num	ber, City or Town,	State, Zip	Code)
e, N	t and thealth sm 27 ther tr		Maryland Gener	ral Hospital		27 Lind	en Avenue	Baltimore	, MD 212		own, State
imor	Pages ment of I ant: If its		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other		cemeter	y, crematory or o					
Baltime	Depentit. Depentit imports eny inj		21. Signature of Funeral Service Roma I d	S Warte Dir	otor	State Balti	d Address of Facility Anatomy B nore, MD	Board 655 21201	W. Baltin	nore	Street
\			3a. Part1 Enter the disea and shoot, or heart failure. Li	or mplication hat cause st only one cause on each i	d the death. Do n	ot enter the mod	e of dying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	<u> </u>					
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8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of	of):					
687	tificate g phys as the	ledical		d							
O. Box 6	Attending Physician: The law requires that the death certificate be executed cleath. coer. After this certificate hes been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _f				te of delive nth	ery Day Year
ds, P.O.	uires that t signed by d be detac		Part II. Other significant condi	itions contributing to death t	out not resulting in	the underlying	ause given in Part I.		I tobacco use cont	ribute to th	he cause of death?
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> >	hysic this ce	ဥ	examiner? 1 □ Yes 20 No	Hospital: 12 Inpati				sing Home 5 Re			y)
ouo	ding P h. After i funera	tion:	27. Manner of Death 1 Natural 5 Peni 2 Accident inve	ding 28a. Date of Injuding (Month, Date of Injuding)	ay Year) 28b. I	ime of njury M	28c. Injury at Work? 1 ∐ Yes 2 ∐ N		e how injury occur	өа	
Oivisi	or Attendi effer death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Cou		jury - At home, fa tc. (Specify)	rm, street, factor	y, office	28f. Location City or 7	(Street and Numb own, State)	er or Rura	al Route Number,
_	To the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 Certific (Check only one)	ying Physician: To the best al Examiner: On the basis of and manner s	of examination and	, death occurred d/or investigation	at the time, date and i, in my opinion, death	f place, and due to the h occurred at the time	e cause(s) and ma e, date and place,	inner as si and due to	tated. o the cause(s)
_	ro the within ro the comple	Me	29b. Signature and title of certi			29	c. License number		29d. Date signe	d (Month,	Day, Year)
			1//				8953	6	8-3	35.	05
_			30. Name and address of person	on who completed cause of	death (Item 23a)	Type, Print)) c/o	Mary	and Ge	rera	Hosta
ø	St Regist	ate rar	31. Kate filed (Month, Day, Ye.	ar) 32. Regist	rar's Signature	South					

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LLSWORTH

		1 - For State Registrar	State of Maryland / D	Department of He Certificate of D		Hygiene Reg. No.	2005	28807
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give st	Mary V Teel and number) Nursing Ce	Jaller 4b. City, Town, gr L	Sep	temper	Year 2005 County of Death	7;20AM
Funeral Director		5. Social Security Number 218–10–7440 6. Sex	7. Age (In yes. last birt		If Under 24 Hrs. 8. Date Hours Min. (Mon	of Birth th, Day, Year) 3/1920	9. Birthplace Country)	e (State or Foreign
death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town	or Location altimore			10d.	Inside City Limits
with the	I Director	10e. Street and Number 1453 Towson Stree	t	10f. Zip Code	21230	10g. Citiz	zen of What Country? USA	?
<u> </u>	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		panic Origin? (Specify Yes Mexican, Puerto Rican, e Specify:		4. Race - American Black, White, etc. Specify: Whi	
21215-0036 within 72 hours af piene. It ham "natural", or the wedical Exam.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired) Homemake	ring most of working		od of Business/Indust	iry
Viand 2 Jud be filed Mental Hygic arked other attic event, II	To Be C	17. Father's Name (First, Middle, Last) Joseph Momagha:	n	1	8. Mother's Name (First, Manne Co. Nellie Co.	Middle, Maiden onnolly	Sumame)	
Mar d 2 sh th and 7 ts m traum	F	19a. Informant's Name/Relationship (Type Patricia Hemler /		Mailing Address (Street and 3445 Tyler Di	d Number or Rural Route rive, Ellico	Number, City or tt City	Town, State, Zip Co MD 21042	de)
ore, of Heal of Heal or other		20a. Method of Disposition 1208 urial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State Glen	Disposition (Name of y, crematory or other place) Haven Cemete	Date 09/06/2		cation - City or Town, ltimore MI	
Baltim permit. Pag Department important: any injury o		21. Signature of Funeral Service License	Victor P. Doda	Charles L. 1501 E. For	Stevens Fune t Ave., Balt	ral Home imore M	e, Inc. D'21230	
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ry arte offes me entia	such as cardiac or respire		Int Or	Je ars
I Records, P.O. Box 681. The law requires that the death certificate are has been signed by the attending phypage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery Month Da	у Үөаг
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al Records, The law requires to cate has been signed, page 2 should be cate.	Completed				1 🗆	a. Was an autopsy performed? Yes 2 XNo	24b. Were autopsy prior to compl death? 1 Yes 2	letion of cause of
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation		Utpatient 3 DOA Other Time of 28c. Injury Injury Work?	4 Nursing Home 5			
Divis	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		ation (Street and or Town, State	d Number or Rural R)	oute Number,
Div To the Hospital or within 24 hours afte To the Funeral Dire completely filled in b	Medical C	29a. Certifier 12 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowledge er: On the basis of examination are and manner stated.	e, death occurred at the time nd/or investigation, in my opi	e, date and place, and due nion, death occurred at the	to the cause(s) e time, date and	and manner as state I place, and due to the	ed. e cause(s)
To th within To th	ğ V	29b. Signature and title of certifier	mo mo	29c. License	1-391	29d. Dat	e signed (Month, Day	y, Year) 2005
		30. Name and address of person who co	Mendeted cause of death (Item 23a)	(Type, Print) V en ve,	Baltin	ore. N	1 any lan	id 2122
S Regis	tate trar	31. Date filed Moeth, Day, Year) SEP 0 2	2005 Registrar's Signature	y Sparke	,		1	

amend item#20b, perFH, 6847, 9/2/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2005 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST 30, 2005 ANITA WAGENHEIM 11:12 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE-GILCHRIST CTR. TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year)
DEC.22, 1924 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1□M 2∏F 80 Director 219-16-9293 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural" ~ " any injury or other traumatic even." 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2403 SYLVALE ROAD 21209 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 X No Specify: WHITE Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTANT ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be COHEN FRANK MAMIE ALTSHUL ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN WAGENHEIM / HUSBAND 2403 SYLVALE ROAD - BALTIMORE, MD 21209 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/1/2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 097 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final stroke **Physician** Deeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician end for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificete 1 ☐ Yes 2000 the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPLE 2 1 ☐ Yes 2000No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending deeth. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospiter within 24 hours after d To the Funeral Direc 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AUGUST 30 2005 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TONSON, UND ELECT

State

Registrar

Mer

SEP 0 2 2005

31. Date filed (Month, Day, Year,

6601 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No 2005 2880
1. Decedent's Name (First, Middle, Last) Physician	11101/110	2. Date of Death Month Day Year 3. Time of Death
Medical Sarare	Wallace	August 30, 2005 00:15.
Examiner 4a Facility Name (If not institution: give street and number)	4b. City, Jown, or L	ocation of Death 4c. County of Death NA
Cromwell Nurs	yrs (and hinthday) If Under 1 Year If Under 24 Hrs.	111001
Fulleral 1 M 2X F 7C	yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
Director 217-20-8078 // Usual Residence of Decedent		5-25-29 Md.
10a. State 10b. County 10c	. City, Town or Location	10d. Inside City Lin
10a. State 10b. County 10c	Baltimore	Y Yes 2□
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10a. State 10b. County 10c 10c 10c 10c 10c 10c 10c 10	#301 21213	USA
Md. NA 10e. Street and Number 1401 N. Lakewood Avenue 11. Marital Status 1 Never Married 2 XMarried 1 Yes 2 XNo		
11. Marital Status 12. Was Decedent Ever Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		o Rican, etc.) Black, White, etc.
1 Yes, Give Year or Dates:	1 ☐ Yes 2 💆 No Specify:	Specify: Black
3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
	(Give kind of work done during most of work life. DO NOT use retired)	ting
10th grade	Manager	Supermarket
17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Surname)
Elementary/Secondary (0-12) 10th grade 17. Father's Name (First, Middle, Last) ISAAC 19a. Informant's Name/Relationship (Type, Print) Carolyn Scott Daughte 20a. Method of Disposition	Perez Lula	Moultrie
19a. Informant's Name/Relationship (Type, Print)		ral Route Number, City or Town, State, Zip Code)
Carolyn Scott Daughte	r 1401 Lakewood Aver	nue #301, Baltimore, Md.
Carolyn Scott Daugnte	b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		9-3-05 Baltimore, Md.
A Denote of Funeral Service Licensee	22. Name and Address of Facility	Baltimore, Md. 21202
21. Signature of Purieral Service Licensee	March F.H. East	430VW - 125 125
23a. Part1. Enter the disease, or complications that caused the		
a	to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury training that initiated events	(
<u> </u>	o (or as a consequence of):	
Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of de-
the End Stage of Ros	rul Disease	1 Yes 2 No 3 Probably 4 Vonkr
200		24a. Was an autopsy performed? 24b. Were autopsy finding available prior to completion of cause of death?
page Page		1 Vec 1 No 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 Vo	26. Place of Deat	th (Check only one)
25. Was case referred to medical examiner? 1	2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 28a. Date of Injury (Month, Day Yea	28b. Time of 28c. Injury at	28d. Describe how injury occurred
1 Matural 5 Pending (Month, Day Year	M 1 ☐ Yes 2 ☐ No	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (Sp	At home, farm, street, factory, office ecify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check only 2 Medical Examiner: On the basis of exam	knowledge, death occurred at the time, date and place, nination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d, Date signed (Month, Day, Year)
1 Mentedley we	200559855	Guerra 30 2005.
30. Name and address of person who completed cause of death	(Item 23a) (Type Print)	Madas, 10
2 Stratin Gas, 560/ L	och Raven Block	Bulhimore MD 2/23
State 31. Date filed (Month, Day, Year) 32. Registrar's S	ignature 2	

Physici	an	State of Marylan 1 - State Unpend Item 23a,27,28a-f p 1. Decedent's Name (First, Middle, Last)	Ce	rincate of L	Jeain	2. Date of Death Month	2005	327 in 8 08 oan
/Medio	cal	BOBBY RYDELL WALLACE				AUGUST	24, 2005	
Examir	ier	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND		4b. City, Town, or			4c. County of Dea	ith
Funeral		Social Security Number 6. Sex 7. Age (In yrs.)	last birthday)		If Under 24 Hrs.	8. Date of Birth	N/A 9. Bir	thplace (State or Foreign
Director		1/1 M 2 T E	13 Yrs.	Months Days	Hours Min.	(Month, Day, Ye OCT • 24	ar) C	ountry) IRGINIA
how		10a. State 10b. County 10c. Cit	y, Town or Lo	ocation				10d. Inside City Limit
8a-f s	Director	VIRGINIA CHARLES CITY	CHARLES	SCITY				1 ☐ Yes 2 📉
Tor 2	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	ountry?
18 23g	era	10230 BARNETTS ROAD 11. Marital Status 12. Was Decedent Ever in U	C 12	23030	one in Original (Co		U.S.A.	
natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	1 National Status 1 National Status Armed Forces? 1 National Status Armed Forces? 1 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🂢 No	Specify:	Rican, etc.)	14. Race - Ame Black, Whi Specify: B	te, etc.
incommittee incommittee incommental Hygiene. Ital Hygiene.	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wor	king 16b	. Kind of Business	/Industry
giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+) 8th grade	HAI	NDYMAN			PRIVATE	
d other	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Maid	len Sumame)	
smarked c	၉	SUMMERFIELD WALLACE, SR.				NE BROWN		
4 6 5 9		19a. Informant's Name/Relationship (Type, Print) Florine B. Wallace/Mother				ral Route Number, Cit narles Cit		
Department of Heelth important: if Item 27 any injury or other to once.		1 XX urial 2 Cremation 3 Removal from State	lace of Dispo	sition (Name of matory or other place		Date UNK 20c.	Location - City or	Town, State
partm portar y injur	1	21. Signature of Fung I Service Lizensee	22	2. Name and Address	s of Facility	TO 11 25 THE	ARLES CIT	
8 2 2 8		She han		LLLIAM C E		MUNITY FUI	NERAL HON	AE P.A.
physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen						_
g physician as the buria	edical	d.						
ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of december 1 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
y the ette		Part II. Other significant conditions contributing to death but not resu	. Min and in Albania					
n signed by the ette	۾	. a	uiting in the ui	nderlying cause giver	n in Part I.	23e. Did tobacc 1 ☐ Yes		A.
is been signed by the 2 should be detached	Completed by		uiung in the ui	nderlying cause giver	n in Part I.		2 No 3 Pr	obably 4 Unknown
certificate has been signed by the ette frector, page 2 should be detached for	Be Completed by	25. Was case relerred to medical examiner?			26. Place ol De <i>a</i> t	1 Yes 24a. Was an autopsy performed 11 Yes 2 1 h	2 No 3 Pr 24b. Were au prior to death? 1 Dives	obably 4 Unknow utopsy lindings availab completion of cause o
or this certificate has been signed by the etter eral director, page 2 should be detached for	To Be Completed by	25. Was case relerred to medical examiner? 1 ☑ Yes 2 □ No Hospital: 1 □ Inpatient 2 ☑ 27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of	t 3□ DOA Other	26. Place ol Deat	1 Yes 24a. Was an autopsy performed 1 Yes 2	2 No 3 Province au prior to death? No 1 Were au prior to death? No 1 Wes	utopsy lindings availab completion of cause of 2 No
death. ttor: After this certificate has been signed by the ette the funeral director, page 2 should be detached for	To Be Completed by	25. Was case relerred to medical examiner? 1 💢 Yes 2 🗆 No 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 2 □ Accident investigation 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 2 □ Accident investigation 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Pending 1 □ Natural 5 □ Natural 5 □ Pending 1 □ Natural 5 □ Natura	ER/Outpatien 28b. Time of 10:120 found	t 3 DOA Other 28c. Injury Work? M 1 Y	26. Place ol Deat	24a. Was an autopsy performed; 1/20 Yes 2 1/	2 No 3 Pr 24b. Were at prior to death? No 1 Ves 6 Other (Specially occurred	utopsy lindings availab completion of cause of 2 No
iffer death. Director: After this certification by the funeral director,	Certification; To Be Completed by	25. Was case relerred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined to building, etc. (Specify found in vac.)	ER/Outpatien 28b. Time of 10:20 found me, Jarm, stre)	t 3 DOA Other 28c. Injury Work! 1 You eet, factory, office ilding	26. Place of Deat 4 □ Nursing Ho at as 2 ▼ No	24a. Was an autopsy performed 11/0/Yes 2 1/1 (Check only one) one 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Staltimore,	2 No 3 Province and Province And Number or Rules 1300 Waryland	utopsy lindings availatempletion of cause of 2 No 2 No unk ural Route Number, ashington
iffer death. Director: After this certification by the funeral director,	Certification; To Be Completed by	25. Was case relerred to medical examiner? 1 \(\tilde{\tilde{Y}} \) Yes 2 \(\tilde{\tilde{N}} \) No 27. Manner of Death 1 \(\tilde{\tilde{Natural}} \) 5 \(\tilde{\tilde{P}} \) Pending investigation 2 \(\tilde{\tilde{A}} \) Accident 3 \(\tilde{\tilde{Suicide}} \) 6 \(\tilde{\tilde{V}} \) Could not be determined 4 \(\tilde{\tilde{H}} \) Homicide 28. Place of Injury - At ho building, etc. (Specify etc.)	ER/Outpatien 28b. Time of 10:20 found me, larm, stro ant bu:	28c. Injury Work? M 1 You seet, factory, office ilding	26. Place of Deat 4 □ Nursing Ho at es 2 ▼ No	24a. Was an autopsy performed; 120 yes 2 1 th (Check only one) one 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Staltimore, and due to the cause	2 No 3 Pr 24b. Were at prior to death? No 1 Wes 6 Other (Special Prior	utopsy lindings availab completion of cause of 2 No unk ural Route Number, shington
iffer death. Director: After this certification by the funeral director,	To Be Completed by	25. Was case relerred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury 8-24-05 ay Year) 29a. Certifier (Check only) 1 Certifying Physician: To the best of my known of the properties of the pro	ER/Outpatien 28b. Time of 10:20 found me, larm, stro ant bu:	28c. Injury Work? M 1 You seet, factory, office ilding	26. Place of Deat 4 Nursing Ho at bes 2 No 1, date and place, nion, death occur	24a. Was an autopsy performed; 120 yes 2 1 th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Staltimore, and due to the cause red at the time, date a	2 No 3 Pr 24b. Were at prior to death? No 1 Wes 6 Other (Special Prior	utopsy lindings availab completion of cause of 2 No city) unk ural Route Number, ashington stated, to the cause(s)
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ette completely filled in by the funeral director, page 2 should be detached for	Certification; To Be Completed by	25. Was case relerred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury - At he building, etc. (Specify found in vac.) 29a. Certifier (Check only one) 25. Was case relerred to medical Hospital: 1 Inpatient 2 X	ER/Outpatien 28b. Time of 10:20 found me, larm, stro ant bu:	28c. Injury Work? a 28c. Injury Work? a 1 You seet, factory, office ilding n occurred at the time restigation, in my opi	26. Place of Deat 4 Nursing Ho at bes 2 No 1, date and place, nion, death occur	24a. Was an autopsy performed; 120 Yes 2 1 th (Check only one) one 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Staltimore, and due to the cause red at the time, date a 29d. E	2 No 3 Pr 24b. Were at prior to death? No 1 Ves 6 Other (Specially occurred) and Number or Real of 1300 Wary 1 and Number and Num	utopsy lindings available completion of cause of 2 No 2 No cify) unk ural Route Number, shington is stated, to the cause(s) to Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien2005Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yea 2120 James T. Williams ugust 20U5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Itospital Bon Secour 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 03-30-1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Yrs. 215-12-9366 80 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show treumetic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1020 N. Payson Street 21217 TISA items 23e death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "neturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "r College (1-4or 5+) Elementary/Secondary (0-12) Brick Layer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Williams Adelene Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a importent: If item 27 Is any injury or other treuonce. 1020 N. Payson Street Baltimore, MD 21217 Lena Williams/ Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 □Other (Specify) Garrison Forest Vet Cem. 09-06-05 Owings Mills, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive heart tailure disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner artery Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No Division of Vital 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 X No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0035363 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BVAMC 10 N. Greene Street Baltimore, MD

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

SEP 0 2 2005

MD

32. Registrar's Signature

			For State Registrar	Si	tate of	Marylan		artmen rtificate				ental Hyg	jiene eg. No.	ם חם	2.8	812
	Physici	an	1. Decedent's Name (First, Midd	lle, Last)								2. Date of Dea Month	th Day	Year	3. Time	of Death
H	/Media	al	Helen	Doris			all	45 035	T		. (August		2005	7:55	рМ
	Examir	ier	4a. Facility Name (If not institution Genesis Elde:	-		-	ık		apo]	Location o	of Death			county of De nne Ar		
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		If Under	1 Year	lf Under		8. Date of Birth			irthplace (State	or Foreign
y .	Director		217-16-7542	1 □ M	2 ⋈ F	83	Yrs.	Months	Days	Hours	Min.	(Month, Day,	9,10		ountry) aryland	
	pug *		Usual Residence of Decedent 10a. State 10b. Count	v		10c Cit	y, Town or Lo	ocation					-, -,		10d. Inside (Titu Limite
	Manyla f aho ied al	ō		_	~											s 2 No
	r 28a-	irect	10e. Street and Number	n Anne	5	د ا	tevens	10f. Zip	-			1	0g. Citize	en of What C	Country?	
	hours after death with the Maryland tural', or Items 23a or 28a-f ahow at Examinar must be notified at	Funeral Director	506 Bay Dri	ve					2166	66			11.5	.A.		
	ems err	Iner	11. Marital Status	12. \	Was Deced	dent Ever in U.	.S. 13.	Was Deced			igin? (Spe	cify Yes or No- Rican, etc.)			nerican Indian,	
36	s afte , or If	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	.	l ∏Yes 2 f Yes, Give Year or Da)		1 ☐ Yes 2		Specify:			5	Specify:		
21215-0036	d within 72 hours after death with the Marylan giene. Ir than "natural", or Items 23a or 28a-f ahow It e Medical Examinar must be notified at	ed b		nt's Educatio		105.	16a, Dece	dent's Usua	al Occupa	ation			16b. Kind	WJ d of Busines	nite s/industry	
215	within 72 ene. than "nat	Completed	(Specify only high Elementary/Secondary (0-12)	est grade coi	mpleted) College (1-	4or 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired	during mos)	t of workir	ng				
21	filed with Hygiene. ther than	Com	10		onlogo (1		Home	maker					Ow	n Home	9	
nd	d all a	Be	17. Father's Name (First, Middle	, Last)						18. Mothe	er's Name	(First, Middle, I	Maiden S	iumame)		
Maryland	d 2 should be th and Mental 7 Is marked o traumatic eve	2	Charles W.B. 19a. Informant's Name/Relation				10b Maili	na Address	/Street o			Ellen Route Number			7in Codel	
Ma	12 strau		Leslie A. Wall					-				ville,			Zip Code)	
	s 1 and 2 if Health item 27 l		20a. Method of Disposition	I, OI.	501	20b. P	Place of Dispo	sition (Nan	ne of	1					r Town, State	
altimore,	0 0		1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (val from S	tate	adowri			1	9_1_	2005	E11	ridge	MD	
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee	i	110	2:	Name an	d Addres	s of Facilit	hv	neral H		_		
<u>B</u>	89888		1/191	Mai	lon	nan		7250	Wash	ingto	on Bl	vd., El	krid			•
*			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complication t only one ca	ons that ca tuse on ea	used the deatl ch line.	h. Do not en	er the mode	e of dying	g, such as	cardiac o	r respiratory arre	est,	J	Approxima Interval Be Onset and	tween
	Physician / Medical		Immediate Cause (Final disease or condition resulting in death)	I_{a}	s de	nie Co	andio	Mar	all	1					14	
Ac.	Examiner		,		Due to (o	r as a conseq	uence of):	('		ı						
		ler	Sequentially list conditions, if any, leading to immediate	b. —	Due to (d	r as a conseq	uence of):									
1/0	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	5 c												
0,	e exerian ar		resulting in death) Last		Due to (o	r as a conseq	uence of):									
8760,	ate hy:	Physician/Medical		d												
9	eath certific attending pl for use as t	/Me	IF FEMALE:	23c. l	f ves. outc	ome of pregna	incv						22	d. Date of de	liver	
Вох	feath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No			th 2 ☐ Feta Int at time of d		Ectopic pro					23	Month	Day	Year
o.	that the de ned by the a detached i	hysi	9 Unknown		Unknov	wn										
o,	The law requires that the tte bas been signed by the bage 2 should be detache	by P	Part II. Other significant condit	ions contribu	uting to dea	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I.	٠	23e. Did tob	acco use	e contribute	to the cause of	death?
Records,	w require been si should I	ted										1 □ Ye	s 2-2	No 3 □ F	robably 4	Unknown
ec	e law r has be	Completed					-46					24a. Was a autops	y	prior to	utopsy findings completion of	available cause of
E H												perform	No Service	death? 1 ☐ Ye	s 2□No	
Vital	9 9 9	o Be	25. Was case referred to medical examiner? 1 Yes 2 9900	Hospi	ital:				Othe			(Check only on				
of		H	1 ☐ Yes 2 🔀 No 27. Manner of Death	2	8a. Date of	patient 2 Injury	28b. Time o		Bc. Injury Work	4 Nu		ne 5 Reside			9city)	
ion	Attending I r death. sctor: After by the funer	atlor	f Natural 5 ☐ Pendi 2 ☐ Accident invest	ing tigation	(Month	, Day Year)	Injury	М		t? Yes 2 □ i	No					
Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 2	8e. Place o	of Injury - At ho g, etc. (Specify	ome, farm, str	eet, factory	, office		2	8f. Location (St. City or Town		Number or F	lural Route Nur	nber,
ā	Hospital or 24 hours afte Funeral Dir tely filled in l	-		-									,			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	I Examiner:	n: To the bas On the bas and manne	sis of examina	wledge, deat tion and/or in	occurred a vestigation,	at the tim in my op	ie, date and pinion, deat	d place, a th occurre	nd due to the ca d at the time, da	tuse(s) a ate and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the l within 2. To the l complet	Me	29b. Signature and will of centifi	\wedge				29c	. License	number		25	9d. Date	signed (Mon	th, Day, Year)	
)			→ /3 //	Spr	My	M			D	370	36		81	30/	7005	
	Ŋ		30. Name and address of person	who comple	eted cause	of death (Item	8 1)	Print) (V	wh	o D.	iù	Chih	M	11) 2/	6/9	
	Sta Registr		31. Date filed (Month, bay, Year SEP 0	2 2005		gistrar's Signa	ture	este)								
					Later - The of	-	0 1									

			1 - For State Registrar		epartment of Health and Certificate of Death		iene _{9g. No.} 2005	2881
			Decedent's Name (First, Middle, La			2. Date of Deat	h	3. Time of Death
	Physici /Medio		Mary Leister	- Zumbrun		Month	Day Year 26, 2005	7:45 PM
	Examin		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat		4c. County of Deat	h
				and Medical Center			Baltim	eve
	Funeral Director		5. Social Security Number 6. S C96 26 9516	Du abor	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, MAR 16	Year) 9. Birtl Co	nplace (State or Foreign untry) RYLANO
	p		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				
	sho	'n	,		OCHESTER			10d. Inside City Limits 1 ✓ Yes 2 □ No
	the N	ect	MO CARR		10f. Zip Code		Og. Citizen of What Co	
	with	ă	3154 Church	street	21102		USA	unity?
	ter death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	rican Indian,
215-0036	a oE	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 27 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerd 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White	hite
2-0	72 hours 'natural', dicel En	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation 'Give kind of work done during most of work	ting	16b. Kind of Business/l	ndustry
2	be filed within 72 h tal Hygiene d othar than "natu avent, tre Madical	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		CARROLL	
21	Hygier Hygier Ithar th		17. Father's Name (First, Middle, Last)		FETCRIA MANAGE		30 of Eoi	CATION
Maryland		To Be	EMORY C. LET			ne (First, Middle, N DE RH		
ary	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Ru			ïp Code)
			Ronald Zumbru		of Emony CHURCH	rek UPPE	the mo	21155
ore	es 1 an of Heal of Itam 2 or other	1	20a. Method of Disposition 1 Surial 2 Cremation 3 C	Removal from State 20b. Place of l	Disposition (Name of crematory or other place)		20c. Location - City or 1	
Ë	Pages ment of tant: If it		`4 □Donation 5 □ Other (Specifi	MANCHO	STER Union com 9/1	[2005 N	Wancifester	2, m0.
Baltimore	permit. Departir Importa any inju		21. Signature of Funeral Service Licer	umbrum	22. Name and Address of Facility J			
	402 40				6028 SYKCOVILLE I	ecar) EL	nens burg	
		e I	shock, or heart failure. List only	one cause on each line.	`	or respiratory arre	ST,	Approximate Interval Between Onset and Death
	Physician Medical		disease or condition resulting in death)	a Aortic ster				
п	Examiner			b. Myocardial	Defarchou			
		er	Sequentially list conditions,	b. Due to (or as a consequence of):			
V	outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Lower Gartro	intestinal Breed	d		
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of):			
09289	ate hy:	edical		d				
			IF FEMALE:	00-11				
Вох	death certific e attending p id for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of deliver Month	very Day Year
	0 0 0	yslc	1 □ Yes 2 ☑ No 9 □ Unknown	4□ Pregnant at time of death 9□ Unknown	5 Other (specify)			,
P.O.	law requires that the as been signed by th 2 should be detache		Part II. Dther significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	quires n sigr	d by				1 □ Yes	s 2 No 3 Pro	bably 4 Unknown
Records,	aw requir is been si 2 should	Completed				24a. Was an	24b. Were aut	opsy findings available
R	9 4 9	E O				autopsy perform 1 Yes 2	ed2 death?	ompletion of cause of
Vital	sician: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?		26. Place of Dea	th Check onl one		200110
of V	di S	10	1 Yes 212 No	Hospital: 1 ☐Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: 4 Nursing H	ome 5 Resider	nce 6 Other (Speci	(fy)
D C	ing Ph	ou:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tii	ury Work?	28d. Describe how	w injury occurred	
sio	Attending r death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	after of Dirac	Certification;	4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28t. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge,	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cau	use(s) and manner as	stated.
	To the H within 24 To tha F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Month,	
1	5 7 ½ T		10110	/ Mr				
	.5		30 Name and address of parcon who	completed cause of death (Item 23a) (T	P18589	f	lugust 26	, 2003
	12		Robert Davidso	n 27 Sout	n Greene Street	Baltimore	Maryland	21201
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	^			
	negion	41	CED 0 9 20	INE M. La	and the same of th			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	partment of F ertificate of	lealth and N Death	Mental Hy	giene Reg. No. 20 (05 28814
	Physic		Decedent's Name (First, Middle, La					2. Date of De. Month	ath Day Ye	3. Time of Death 12:20 A ^M
	/Medi Exami		4a. Facility Name (If not institution, gir			4b. City, Town, o	or Location of Death	August	4c. County of	
	Funeral Director		,		n yrs. last birthda 57 Yrs.		nesda If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	h y, Year) 9.	gomery Birthplace (State or Foreign Country) Ethiopia
	D S		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				
	Maryla f eho	20	Maryland Montgom		Potoma					10d. Inside City Limits 1 ☐ Yes 212 No
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
	th with	aiD	10421 Dalebrooke	Lane		20854			United	l States
200	ife; Marylatic ZIZIS-DOSO s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental hygiene. item 27 is marked other than "naturel", or iteme 23s or 28a-1 show other traumatic avent, the Medical Exercipat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13	. Was Decedent of Hif Yes, specify Cuba	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc. Black
245 0025	hin 72 house.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	iducation ade completed) College (1-4or 5+)	(Gis	edent's Usual Occup re kind of work done DO NOT use retired	during most of world	king	16b. Kind of Busin	ess/Industry
Č	ad with	Com		5+	Fi	nancial A			Satel1	ite Services
	ntal H	Be	17. Father's Name (First, Middle, Las. Zawdie Zeweldie	")					Maiden Sumame)	
3	should of Mer mark matic	2	19a. Informant's Name/Relationship	(Tvpa, Print)	19b. Ma	iling Address (Street	Amarach		er City or Town Sta	ite. Zin Code)
	ING 2 salth ar 27 is or trau			on		l Dalebro				
			20a. Method of Disposition 1 X Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from State	ob. Place of Discem <i>etery, cr</i>	position (Name of ematory or other place te of n Cemeter	Sept	Date cember 2005	20c. Location - City	
0	permit. Page Department of Important: If any njury or one.		21. Signature of Funeral Service Lite	1111	F	22. Name and Addre Lobert A. Pu 00 West Mon	ss of Facility	eral Home	Rockville.	Inc.
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	death. Do not e		ng, such as cardiac	or respiratory ar		Approximate Interval Between Onset and Death 1 Week
	Examiner			Due to (or as a co	. ,	'ailura				2 weeks
m	outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):	tastatic	to Liver a	and Bone		4 Months
105	icate be executed physician and sthe burial-transit	edical Ex	resulting in death) Last	Due to (or as a co	nsequence of):					
		an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pi		□Ectopic pregnancy	/		23d. Date of Month	f delivery Day Year
C	ires that the designed by the a	Physician/M	1 □ Yes 2 X No 9 □ Unknown	4□Pregnant at time 9□Unknown		Other (specify)				,
20man	The law requires that the death certified has been signed by the attending tage? Should be detached for use a	Completed by	Part II. Other significant conditions Disseminated in				en in Part I.			te to the cause of death? Probably 4 Unknown
07 0		Somple	End-stage renal from her son in		tus-post	renal tr	ansplant	24a. Was autop perfor 1 Yes	sy prior med? deat	e autopsy findings available to completion of cause of th? Yes 2 \(\subseteq \) No
Vital	vician: The	Be	25. Was case referred to medical examiner?			101	26. Place of Deal			
3) 5	Physic rthis o	5	1 ☐ Yes 2 No 27. Manner of Death		2 ☐ ER/Outpati		4 LI Nursing H		ence 6 Other (Specify)
19	Attending Physician: Ir death. ector: Atter this certifics by the funeral director, f	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	₩or	k? Yes 2 □ No	28d. Describe II	ow injury occurred	
Zawdie,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined		At home, farm, s	street, factory, office		28f. Location (S City or Tow	treet and Number o	or Rural Route Number,
. •	he Hospital or in 24 hours affe he Funeral Dir pletely filled in I	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	nysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, dea mination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the orred at the time, or	ause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	Moite	MA	29c. Licens		=:	29d. Date signed (M	
	ì		> Mishael a.				2451 		August :	31, 2005
	þ		30. Name and address of person who Michael A. Weste	rman, M.D. 8	3600 Old	Georgetow	vn Road, B	ethesda,	Maryland	1 20814
	Sta Regista	ate rar	31. Date filed (Month, Day, Year) SEP 0 2 20	32 Registrar's S	Signature	edi!				

			1- For Amend Item Ragistrar	State of Marylan	d Departme	nt of Health and 05dbb <i>te of Death</i>	Mental Hygie	ene	
l	Physic	ian	1. Decedent's Name (First, Middle, La		BELEIL	1	2. Date of Death	Day Year	3. Tilfre of Debut
	/Medi Examir		4a. Facility Name (If not institution, giv			y, Town, or Location of Dea	1041 0	4c. County of Death	0.30 "
	LXamii	101	ELSESV ,	MANOR		BALTIMO	KE	BAITO	do.
	Funeral Director		5. Social Security Number 6. S 214-24-51/ Usual Residence of Decedent	Sex 7. Age (In yrs.	last birthday) If Und Yrs. Month:	er 1 Year If Under 24 Hr B Days Hours Min		ear) 9. Birthp Coun	ace (State or Foreign try)
	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28a-f ehow the Madical Enaminar must be notified at	_	10a. State 10b. County	10c. Cit	y, Town or Location			10	0d. Inside City Limits
	28a-1	Funeral Director	10e. Street and Number	$D \cdot D$	HE 11401	ip Code	100	. Citizen of What Coun	
	3a or	ā	4010 Buck	INE HAM &	().	21207	109	1) 5.A	uy:
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - America	
036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow other traumatic event, Ira Medical Exertirer must be notified at	5	1 ☐ Never-Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		2 No Specify:	nto moan, oto.,	Specify:	4iTE
5-0	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Us	ork done during most of w	orkina 16	b. Kind of Business/Ind	ustry
21215-0036	d within piene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOME	MAKER		DINN A	60ME
	be filed tal Hygie d other	BeC	17. Father's Name (First, Middle, Last,	' V	10110	18. Mother's Na	ame (First, Middle, Mai	iden Sumame)	
Maryland	should be ind Mental marked o umatic eve	2		UNKNOW		L	INKNOU	W	
Ma	d 2 sho		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addre	ss (Street and Number or F	Rural Route Number, C	ity or Town, State, Zip	Code) 21204
ē,	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition		lace of Disposition (N	ame of	Date 200	c. Location - City or Ta	wn, State
Ē	8 = 5		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specil	Tuettional itotti State	emetery, crematory or EER (REE	EM. A	2005 7	FARFORD (6. MD
Baltimore,	permit. Pag Department Important: any Injury o		21. Sonature Fur eral Service Licer	Sparko	2P. Name	and Address of Facility	2829 14	PSON 51	24
			23a. Part1. Enter the disease, or com shock, or heart failure. Est only	plications that caused the death one cause on each line.	n. Do not enter the mo	de of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
delation	Physician		Immediate Cause (Final disease or condition resulting in death)	CHRONIC	- (ors)	OVASCUL	.AR FOI	URE	Onset and Death
	/Medical Examiner			Due to (or as a consequence	uence of):				
		ner	Fequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	-			
	and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	sate be executed hysician and the burial-transit		reseming in death, cust	Due to (or as a consequ	uence of):				
9	ificate g phys as the	edical		d.					
Вох	eath certific ettending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic			23d. Date of deliver	y Day Year
o.	at the de by the tached	hysic	1 ☐ Yes 2 💆 No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5 Other (s	pecify)			
ds, P	es tha	þ	Part II. Other significant conditions of	contributing to death but not rest	-	cause given in Part I.	23e. Did tobac	co use contribute to the	~
cor	w requir s been si should	iete	PRTERIO SCLE	STICS CARD					sy findings available
- Re		Completed					autopsy performed	prior to com death?	pletion of cause of
Vita	<u>=</u>	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)		
of	Phys this al dir	7.	1 Yes 2 No.	1 Inpatient 2	ER/Outpatient 3 C		Home 5 ☐ Residence		Assisted Living
ion	nding ath. r: Afte e fune	atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	204. 20301120 1104 1	njury cocurred	11112118
Division of Vital Records,	l or Atte after de Directo in by th	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowniner: On the basis of examinat	wledge, death occurre- tion and/or investigatio	d at the time, date and place n, in my opinion, death occ	e, and due to the causeurred at the time, date	e(s) and manner as sta and place, and due to	ted. the cause(s)
	To the b within 2 To the F complete	Mec	29b. Signature and title of certifier	and manner stated.	25	c. License number	29d.	Date signed (Month, D	y, Year)
			Hound	15. Ok	an or i)	7211	080	8/10	105
NE -	(6)		30. Name and address of person who	busic Ha	E1647	. S AVE	HUE	BALTO	01 D -
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 2 2005	32. Registrar's Signal	ture Control		-	3	1215

		•	1- State of Maryland / Department of Health Certificate of Deat	n and Ment <i>th</i>	al Hygien Reg. N		28816
	Physicia	ın	Decedent's Name (First, Middle, Last) CHARLOTTE RUTH ATHERTON		ate of Death onth CEMBER	^{ay} 1, Ž [®] a'05	3. Time of Death 3:50 a ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatio 4b. City, Town, or Locatio 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatio 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number) 4c. Facility Name (If not institution, give street and number)			c. County of Death	
	Funeral Director				ate of Birth fonth Day Yea		ace (State or Foreign ry) PA
	or death with the Maryland Items 23e or 28a-f show permissible mutilized at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD CARROLL HAMPSTEAD			10	nd. Inside City Limits 1 ☐ Yes 2 No
	with the 3e or 28a	i Director	10e. Street and Number 10f. Zip Code 18712 FALLS ROAD	21074	1 2 2	Citizen of What Count USA	ry?
036	af a	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 XWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexic 1 Yes, Sive Year or Dates:		es or No- , etc.)	14. Race - America Black, White, e Specify: WHI	itc.
1215-0036	be filed within 72 hours tal Hygiene. d other then "naturel", event, tre Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) HOMEMAKER	most of working		Kind of Business/Ind	ustry
Maryland 2121	illed Hygi other ent, I	To Be Co	17. Father's Name (First, Middle, Last) 18. Mo	other's Name <i>(Fir</i> s	t, Middle, Maide	an Sumame)	
	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic es	-	19a. Informant's Name/Relationship (Type, Print) DARLENE STOCKSDALE granddaughter 18712 FA				
Baltimore,	Pages 1 ament of He ent: If item lury or oth		' 4 ☐ Donation 5 ☐ Other (Specify)	SEPT. 2	2, 200		ORE, MD.
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Factorian Service Licensee 16924 YORK				
	Pnysician /Medical	k (i	23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	as cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death
Ÿ	Examiner	-	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): b. Due to (or as a consequence of):				
	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cross (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c				
c 68760,		Medical	d				
.O. Box	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delive Month	ry Day Year
1	w requires that the de been signed by the should be detached	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 2	23e. Did tobacco	o use contribute to th	e cause of death?
I Records,	sicien: The law re certificate has bee irector, page 2 sho	Completed			24a. Was an autopsy performed?	prior to cor death?	osy findings available inpletion of cause of
Vital	sicien: certific lirector,	Be	examiner? Haspital:	lace of Death (Che		6 ☐Other (Specify)
n of	ing Phy After this uneral d	ion; To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work? 28c. Injury at Work?	28d. [Describe how in		/
Division of	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Street City or Town, Sta	and Number or Rura ate)	Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated.				
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number 29c. License number 29c.	0 6 5	29d. D	Date signed (Month, I	Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN SHAFFER 2111 HANOVER PIKE, HAM	MPSTIF AD	, MD.	21074	
• .	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 6 2005 SEP 0 6 2005	II O I LIAD	, m.	210/4	
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		•	For State Registrar	State of Marylar		artment of H			ne 2005	28817
ı	Physicia		1. Decedent's Name (First, Middle, Las	1 (1				2. Date of Death Month SEPTEMA	Day Yea	
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	M	4b. City, Town, or	1 1 /		4c. County of De	Poath MORE
	Funeral Director		212-44-0100	ex 7. Age (<i>In yr</i> s.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. E	Birthplace (State or Foreign Country) MD
	faryland	or	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28e-1	Funeral Director	10e. Street and Number	TIMORE	OWIN	GS MILLS 10f. Zip Code		10g.	Citizen of What	Country?
	death w	neral	4730 ATRIUM COU	RT #123 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	21117	Specify Yes or No-		USA merican Indian,
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event, the Medical Examination and the notified at		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	no rican, etc.)	Black, W	WHITE
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Maryland	should be and Mental markad o	To Be	SOLOMON		SOBE		SARÁH			FRANK
	1 and 2 sh Health and em 27 is m		DÂVID GINSBERG	**				lural Route Number, C NGS MILLS,	•	
Baltimore,	Pages 1 and of He int: If item int or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cre	osition (Name of matory or other place UNO ARLIN	-		RΔI TIM	ORE, MD
Baltin	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar to once.		21. Signature of Uneral Service Licer		2:	2. Name and Addres	ss of Facility S	OL LEVINSOI ROAD - PII	N & BROS	., INC.
Ç			23a. Part1. Enter the disease, or com shock, or heart failure. List only	ome cause on each line.	th. Do not en	er the mode of dyin	g, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st fy)	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or state)	Rural Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical (29a. Certifier (Check only one)	ysician: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, de <i>a</i> t ation and/or in	h occurred at the tin vestigation, in my op	ne, date and plac pinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To the H within 24 To the Fi complete	W	29b. Signature and title of certifier	en le)	29c. License			Premae	nth, Day, Year) My, '2005
1,	7		30. Name and address of person who	IMP, NHC B	ALT	Print) M	021	133		
,	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6 20	32, Registrar's Sign	ature					
DH	MH 17 Rev 1/2		0 0 20	Je gue 1	1. 190					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens 28818 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Le Roy Allen Britz September 3, 2005 12:55 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Forest Haven Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, MAY 10, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1₩ 2□ F Yrs. Director 168-30-1810 68 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mudical Experimental pages. 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Catonsville Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 701 Edmondson Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: δ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Photography 4 Photographer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charlotte Forker Herman Britz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Warwick Road Lawnside, NJ 08045 Kith Johnson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 09/06/05 Metro Crematory, Inc. Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Gregorchik Edward A. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Visease Physician Pavs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death ed by the a signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 200 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 12 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eisterstown MD 32. Registres Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

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arylan show	_	10a. State 10b. County	10 <u>c. (</u>	City, Town or Location					10d. Inside City Limits
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To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Example 1	ysician: To the best of my kr liner: On the basis of examin	nowledge, death occurre lation and/or investigation	ord at the time. date a	and states and eath occurred a	due to the nause(s) t the time, date and	and rametaset diplace, and due to	uted.
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eral ctor		5. Social Security 217-18-9		Gex 1 □ M 2 🔀 F	7. Age (In yrs	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs.	8. Date of Big (Month Da	1922	9. Bi	rthplace (State of
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	þ		rried 2 Marned	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2 / No e		Was Decede If Yes, specif		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	1	4. Race - Am Black, Whi Specify: Wh	ite, etc.
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			Name/Relationship (, ,,	10.2							Town, State,	Zip Code)
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16	0	examiner?	No	Hospital: 1 🗆 In	patient 2] ER/Outpatien	3□ DOA	Other	~		Check only o		y Other (Spe	city) HOSPI
	Certification:	27. Manner of Dea 1 Matural 2 Accident 3 Suicide	th 5 ☐ Pending investigation 6 ☐ Could not be		f Injury n, Day Year)	28b. Time of Injury	28c	: Injury (Work? 1 🗆 Yo	at ? es 2 ⊡ No	- 1	d. Describe h	now injury	occurred	
		4 Homicide	determined	buildin	g, etc. (Special					1	City or Tow	m, State)		ıral Route Numb
	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the l niner: On the ba and mann	sis of examina	owledge, death ation and/or inv	occurred at estigation, in	the time my opi	e, date and nion, death	place, and occurred	d due to the o at the time, o	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	Σ	29b. Signature and	title of certifier				29c. L	icense	number			29d. Date	signed (Monti	h, Day, Year)
		•		-/-)43	725	_			7/6	105

		1	For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of rtificate o			giene Reg. No 20	05 28821
	4 77		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	ith Day	3. Time of Death
	Physici /Medic		Charles		Е.	Bla	gmond	August		2005 10:22 PM
	Examin	4.	4a. Facility Name (If not institution,	0 - 1	er)		, or Location of D	eath	4c. County	y of Death
			Sinai Hospital o			Baltim		Hre o Day (Dis		O Birth I (Oh)
	Funeral		5. Social Security Number 213–18–7032	5. Sex 7. 1%∑M 2□F	Age (In yrs. last birthday 84 Yrs.	Months Day		Min. (Month, Da)	, Year)	Birthplace (State or Foreign Country)
	Director	-	Usual Residence of Decedent		04			12 2	7 21	MD
	yland		10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	or 28a-f ehow	cto	MD NA		Baltimo					1 X Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code				What Country?
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	rai	6612 Dalton S	12. Was Decede	ent Ever in 11 S		21207	2 (Specify Ves or No-		S • A •
		Funeral Director	11. Marital Status 1 □ Never Married ★ Marrie	Armed Force				? (Specify Yes or No- uerto Rican, etc.)	Bla	ack, White, etc.
036	72 hours after death with the Maryla natural; or ttema 23a or 28a-1 ehov dical Examinar must be noutled at	þ	3 Widowed 4 Divorced	ff Yes, Give Year or Date		1 □ Yes 2⁄X N	lo <i>Specify:</i>		Specif	^{fy:} Black
5-0036	n 72 hours "natural", adical Ex	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occ e kind of work dor	ne during most of	working	16b. Kind of B	Business/Industry
2121	불 . 도 회	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	Packer	•	1	Feekan	Meat Co.
2	be filed withir ital Hygiene. id other than event, the M	e Co	7th grade 17. Father's Name (First, Middle, La	na		Facker		Name (First, Middle,		
Maryland	o a a	To Be	William Blagm				Lill	ie Hyde		
ary.	2 should be and Mental Is marked aumatic ev	-	19a. Informant's Name/Relationshi		19b. Mai	ling Address (Stre		r Rural Route Numbe	r, City or Town	ı, State, Zip Code)
	5 2 E		Sarah Blagmon	d-Wife	661	2 Dalto	n Stre	et, Balt:	imore,	Md 21207
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. Place of Disp cemetery, cr	oosition (Name of ematory or other p	olace)	Date	20c. Location	- City or Town, State
Ē	Pag ment ant: I		4 Donation 5 Other (Spe	ecify)	Garris			• 9/9/05	Owing	s Mills, Md
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of uneral Service Li	censee	2	22. Name and Ado March F	/H Wes	t		
	20 = 0		23a. Part1. Enter the disease, or o	omnication that cau		4300 Wa	bash A	ve, Balt		Md 21215 Approximate
			shock, or heart failure. List o	nly one cause on each	h line.	ì		olde or respiratory as	, 651,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)		as a consequence of):	hemor	rhage			13 days
- 4	Examiner			1 1	ra cerebral	hema	haue			19 2015
1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	as a consequence of):	110111111				5300
/	cuted nd ransit	Examiner	that initiated events	· · ·	pertension					20 years
30,	be executed sicien and burial-transit	E	resulting in death) Last		as a consequence of):					20,000
37	hy:	dical		d	ibetes Melli	tus				20 years
9 X	leath certific attending pi	/Me	IF FEMALE:	23c. If yes, outco	me of pregnancy				23d Da	ate of delivery
Вох	atten affor u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No			☐Ectopic pregna ☐ Other (specify)				onth Day Year
P.O.	at the de by the a	hysi	9 Unknown	9□ Unknow	n			-		-
ω̂.	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as:	by P	Part II. Other significant condition	s contributing to deat	th but not resulting in the	underlying cause	given in Part f.			ntribute to the cause of death?
rd	w require been sig	ted						1 0 1	′es 2□No	3 Probably 4 Unknown
Division of Vital Records,	e law r has be je 2 sh	Completed						24a. Was	an 24b.	Were autopsy findings available prior to completion of cause of
<u>=</u>		Con						1 Tes	rmed? 2 X No	death? 1 ☐ Yes 2 🔀 No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	Death (Check only o		
o	Phye r this ral di	5 T	1 Yes 2 No	28a. Date of (Month,		BIIL 3 DOA	4 □ Nursi njury at Vork?	ng Home 5 Resid		
on	Attending Physician: r death. sctor: After this certifica	tion	1 ♣ Aatural 5 ☐ Pending 2 ☐ Accident investiga		Ďaý Year) Injury		Vork? □Yes 2□No			
Visi	or Attendiation distribution of the death.	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of	Injury - At home, farm,	street, factory, office	Се	28f. Location (S City or Tox	Street and Num	ber or Rural Route Number,
ā		Certification:	4 La risilligido	building	, etc. (Specify)			Sity of 70k	, 51416/	
1	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical								namer as stated , and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signe	ed (Month, Day, Year)
	->-0		> (sight we	- DO		RE	ES-005		August	30,2005
	51		30. Name and address of person v	no completed cause	of death (Item 23a) (Type	D-i-N				
				ang, DO	Sinai)	tospital .	of Balti	more		
*	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0	6 2005 32. Reg	strar's Signature	tospital				

The street of Number 1 107, Zip Code 1 109, Citizen of What Country? 1317 Kent Avenue 1317 Kent Avenue 1318 Marial Status 13 Mas Decedent of Hispanic Christ, Maccar, Pustral Ricen, etc.) 14 Rease: Annatical Indian, Black, White, etc. 15 Number of Ricen, etc.) 15 Number of Ricen, etc.) 16 Number of Ricen, etc.) 17 Fathwar Named (107) 18 Number of Ricen, etc.) 18 Number of Ricen, etc.) 19 Number of Ricen, etc.) 19 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 11 Pathwar Name (First, Middle, Matter Summer) 12 Number of Ricen, etc.) 13 Number of Ricen, etc.) 14 Number of Ricen, etc.) 15 Number of Ricen, etc.) 16 Number of Ricen, etc.) 17 Fathwar Name (First, Middle, Matter Summer) 18 Number of Ricen, etc.) 18 Number of Ricen, etc.) 19 Number of Ricen, etc.) 19 Number of Ricen, etc.) 19 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 11 Number of Ricen, etc.) 12 Number of Ricen, etc.) 13 Number of Ricen, etc.) 14 Number of Ricen, etc.) 15 Number of Ricen, etc.) 16 Number of Ricen, etc.) 17 Fathwar Number of Ricen, etc.) 18 Number of Ricen, etc.) 18 Number of Ricen, etc.) 19 Number of Ricen, etc.) 19 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 11 Number of Ricen, etc.) 12 Number of Ricen, etc.) 13 Number of Ricen, etc.) 14 Number of Ricen, etc.) 15 Number of Ricen, etc.) 16 Number of Ricen, etc.) 17 Fathwar Number of Ricen, etc.) 18 Number of Ricen, etc.) 19 Number of Ricen, etc.) 19 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc.) 10 Number of Ricen, etc		•	1 - State Registr							Certifica					Reg. No	2005	2	882
44. Facility Name (if not institution, prive afreet and number) Stella Maris Stella			1. Decedent	's Name	(First, Midd.	lle, Last,		nvllis	Broad	dnax				Month	Day	2005 Year		
Social Security Number Social Security Num		- 11	4a. Facility N	łame (If	not institutio	on, give	street and no	imber)			ty, Town, o			ium	4c.			
265-37-2506 www. 49 ns. 100. City. Town or Location Baltimore 100. Street and Number 100. Exp Code 100. City. Town or Location Baltimore 100. Street and Number 100. Exp Code 110. City. Town or Location Baltimore 100. Street and Number 100. Exp Code 110. City. Town or Location Baltimore 101. Exp Code 110. City. Town or Location Baltimore 102. Street and Number 100. Exp Code 110. City. Town or Location Baltimore 103. The Rest Avenue 110. Exp Code 110. City. Town or Location Baltimore 104. Street and Number 100. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location Baltimore 110. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town or Location City. Town State. Exp Code 110. City. Town State. Exp Code 110. City. Town City. Town State. Exp Code 110. City. Town City. Town State. Exp Code 110. City. Town City. Town State. Exp Code 110. City. Town City. Town State. Exp Code 110. City. Town City. Town State. Exp Code 110. City. Town City. Town City. Town State. Exp Code 110. City. Town City. Tow		4	5. Social Se	curity Nu	ımbər		x			Month		If Under 2	4 Hrs.	8. Date of Bir (Month, Da	th y, Year)	9. Bir	thplace (Si	tate or Fore
13 Maria Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Higher Congrit (Specify Yes or Nov. If Yes, Specify Cobbs, Mexican, Poor Notices, Specify Cobbs, Mexican, Poor Notices, Specify Black, White, etc. 12 Yes (2 g) No. 1 Yes (2 g) No.			Usual Resid		Decedent			10	49					Jan 13	, 1956	3	Florida	3
13 Marria Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Higher Corporal (Speechy Yes or No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc.) 14 Race - American Indian, Black, White, etc. 15 Yes (Sp. No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc.) 15 Was Discontinuous 16 No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc. 16 Yes (Sp. No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc.) 16 No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc. 16 Yes (Sp. No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc.) 16 No. If Yes, Seechy Cuben, Mexican, Pourh Richan, etc. 17 Yes, Seechy Cuben, Mexican, Pourh Richan, etc. 17 Yes, Seechy Cuben, Mexican, Pourh Richan, etc. 18 Yes, Seechy Cuben, Mexican, Pourh Richan, etc. 18 Yes, Cuben Cuben Richan, etc. 18 Yes, Cuben Richan, etc. 1	lifted at	ctor		nd	Too. County	,			o. Oily, Town	TOT EGGETION	Ва	altimore						Yes 2 1
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17. Father's Name (First, Micelia, Mazlen Sumame) 18. Mother's Nam	a Medical		Elementa	(Special ry/Secon	fy only highe	nt's Edu est grad	cation e completed)	16a.	(Give kind of a	work done use retire	during most d)		ng	16b. Ki		,	
Metro Crematory, Inc. O9/06/05 Catonsville, Maryland Metro Crematory, Inc. O9/06/05 Catonsville, Maryland 22. Name and Address of Facility Estep Photers Funeral Service. P.A./ 1300 Eutaw Place, Baltimore, Md. 21217 233. Part. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, bring in death of the cause of each line. Immediate Cause, (Final disease) or condition resulting in death) Last Due to (or as a consequence of): Due	tic event, II	Be	17. Father's				oadnax				Logui							
Metro Crematory, Inc. 09/06/05 Catonsville, Maryland 1			Harry Broadnax 19a. Informant's Name/Relationship (Type, Print)						19b	19b. Mailing Address (Street and Number or Rural Route Number						ber, City or Town, State, Zip Code)		
23a. Part . Enter the disease, or complications that caused the death bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on each line. NON SMALL CELL LUNG CANCER Due to (or as a consequence of): 5. Due to (or as a consequence of): 5. Due to (or as a consequence of): 6. Due to (or as a consequence of): 7. Due to (or as a consequence of): 8. Due to (or as a consequence of): 9. Due to (or as a consequence of): 9. Due to (or as a consequence of): 10. Due to (or as a consequence of): 11. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contributing to death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contributing to death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contributing to death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contributing to death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contribution of death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contribution of death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contribution of death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contribution of death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contribution of death but not resulting in the underlying cause given in Part I. 12. Sequentially its conditions and the contribution of death but not resulting in the underlying cause given in Part I. 12. Seq	inguity of the		1 □ Bur 4 □ Dor	ial 2 🕽 nation	Cremation 5 ☐ Other (S	Specify)			cemeter	y, crematory o	r other pla	· ·						
Sequentially list conditions, farry, leading to surround cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C.		- 4	•	D	eral Service	Licens	1/8		tox	22. Name	and Addre	ss of Facility	unera	l Service.	P.A./		, ,,,,,,,	ard .
23c. If yes, outcome of pregnancy 1	ian		23a. Part1. shock, Immediate disease or disease or disease	Enter the or heard	e disease, o t failure. List	or compli	ications that ne cause on	each line. SMALL	death. bor	22. Name	and Addre Estep B 1300 Eu ode of dyir	ss of Facility rothers F Itaw Plac Ig, such as c	unera ce, Ba	al Service. altimore, M	P.A./ ld. 21		Approx Interva	imate I Between
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3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)	director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Exa	23a. Part 1. Shock, Immediate disease or cresulting in Sequentially if any, livating cause. Enter Cause (Disease Enter Instituted resulting in Cause In the part II Year II Year II Other	Enter the or head of the condition of death) It is to condition of the co	e disease, o trailure. List failure. List inal ditions, trainal hying nijury ast pregnant nonths? No cant conditi	ions cor	Due to Due to Due to Due to Due to Contributing to contri	each line. SMAIL (or as a column of pointh 2 continue) and at time lown	CELL prequence of the property of the propert	22. Name LUNG C. It is a second of the modern of the mod	and Addresstep B 1300 Eurode of dyir ANCER	ss of Facility rothers F Itaw Place ag, such as c 26. Place 6	unerace, Baardiac o	23e. Did to 1 Yes Check only of	P.A./ Id. 21: rest. 21: rest. 22: chacco us red? 21: No ne	23d. Date of dei Month se contribute to No 3 Pr 24b. Were au prior to peath? 1 Yes	Approxinterva Onset	Year of death? Tallunknowngs availabiol cause of
29a. Certifier 19 Certifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(a) and many	ing this calificate has been signed by the attending priyation; and in calificate has been signed by the attended for use as the burial-transit.	To Be Completed by Physician/Medical Exa	23a. Part1. shock, Immediate disease or resulting in Sequentially if any, leading cause. Enter Cause (Dise that initiated resulting in cause. Enter the cause (Dise that initiated in the part II. Other 1	Enter the or heart of cause (Fondition death) I list connig to ming to ming to ming to ming runder the control of the control	e disease, o trailure. List failure. List fa	ions cor	Due to Due to Due to Due to Due to Contributing to contri	each line. SMAIL (or as a column of pointh 2 continue) and at time lown	CELL prequence of the property of the propert	22. Name LUNG C. St): 3 Sectopic 5 Other (pregnancy specify) ause giv	en in Part I. 26. Place of the control of the cont	of Death	23e. Did to 1 Yes Check only o	P.A./ Id. 21 rest.	23d. Date of dei Month se contribute to No 3 Pr 24b. Were au prior to death? 1 Yes	Approxinterva Onset	Year of death? Tallunknowngs availabiol cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day Year)	If this certificate has been signed by the attending physicien and ID 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	To Be Completed by Physician/Medical Exa	23a. Part 1. Shock, Immediate disease or cresulting in Sequentially it sity, Isaanic cause. Enter Cause (Disease Enter Cause) (Disea	Enter the or head of the condition of death) It is to condition of the co	e disease, o trailure. List failure. List fa	ions consider the state of the	Due to Due to Due to Comparison of the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause of the ca	SMALL (or as a color of point) (or as a color	CELL CREATE CONSEQUENCE CONS	22. Name LUNG C. Strict Str	pregnancy specify) cause give	en in Part I. 26. Place of the control of the cont	of Death	23e. Did to 1 Yes Check only O. 8f. Location (S	P.A./ d. 21: rest. pbacco us yes 2 [an sy med? 2 No ne) lence 6 low injury	23d. Date of dei Month se contribute to death? 24b. Were au prior to death? 1 Yes	Approxinterva Onset	Year of death? Year square and Death

DHMH 17 Rev 1/2001

State Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

SEP 0 6 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year EVIC eptembr 3:10 Am 2005 /Medical 4c. County of Deeth 4b. City Town, or Location of Death 4a Fecility Neme (If not institution) give street end number) Examiner 10m Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sex In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2□ F 437-50-2966 68 Director Feb. 4 1937 LA Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours aftar death with the Manyland ment of Health and Mentel hygiene. and if item 27 is marked other than "netural", or items 23s or 28s-f show ant: if item 27 is marked other than "netural", or other traumatic event, the Medical Examiner man be notified at my or other traumatic event, the Medical Examiner man be notified at 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 27 is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Medical Evanduer must be notified at Director MD 1 ☐ Yes 2 ☐ No Baltimore Towson 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 1017 Marleigh Circle Funeral USA 21204 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Ves 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: ð white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 3 Racing Starter Horse Racing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eric Wolfston Blind ပ Emma Corcoran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna B. Blind/wife 1017 Marleigh Circ., Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/3/05 Depertment of P important: If ite any injury or ot 1 D∕Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21 Signature of Funeral Service Licensi 22. Name end Address of Fecility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Bryan W. Inc. Clar 23a. Pert1. Enter the disease, or complications that cal shock, or hear failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of): r use es l ata has been signed by the page 2 should be detached Part II. 9ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Medical Certification: To Be Completed certificata has TE Yas 2LINO 1 ☐ Yes 2 ☐ No ours after death.

erai Director: After this certifice filled in by the funerel director, I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mann of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Yeer) 200 idress of person who completed cause of death (Item 23a) (Type, Print) 0 nince -och 31. Deter ed (Month, Day, Year) 32. Registrer's Signature State SEP 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 = State Registrar		Cer	tificate of I	Death		Reg. No. 2005	28824
	Physici /Medio		Decedent's Name (First, Middle, Las JAMAR	BROWN				2. Date of Dea Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give 6000 Martin Luthe	er King Avenue			hington	h	Prince Ge	
	Funeral Director		5. Social Security Number 6. Security Number 198-1806 1991 1991 1991 1991 1991 1991 1991 19	7. Age (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da Septem	h 1981 9. Birt y, <i>Year</i> 9 WAS	nplace (State or Foreign untry) HINGTON, DC
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-1 show imatic event, the Madical Examinat must be notified at	Funeral Director	10a. State 10b. County	George's U		Marlboro 10f. Zip Code			10g. Citizen of What Co	10d. Inside City Limits 1 ★ Yes 2 No
	th with	ai D	11405 Abbotswood	Court			20774		U.S.A.	•
036	urs after dec al', or items Examiner m	by	11. Marital Status 1 ∰ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)	Specify:	
21215-0036	72 ho "natur	Completed	15. Decedent's Ed (Specify only highest grad		16a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wo	rking	16b. Kind of Business/	
121	within iene. than	omp	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		00 NOT use retired Me chanic			Private	
משני	e filed v al Hygie I other t vent, th	BeC	17. Father's Name (First, Middle, Last)		Auto	THE CHAILLE		ne (First, Middle,	Maiden Sumame)	
Sa	should be filed vand Mental Hygies marked other tumatic event, III	To E		r.				A. Demp	•	
, Maryland	and 2 sealth ar n 27 is		19a. Informant's Name/Relationship (7 Yvette A. Banks/M				and Number or Re ood Cour	-	r, City or Town, State, Z Marlboro, M	io Code) aryland 20774
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Removal from State Ft.	Linco	sition (Name of patory or other place oln Cemet	ery 9/2/		20c. Location - City or 3	ryland
Bai	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	hall	74	474 Lando	ver Rd.	Landover	ins Funeral	Home 20785
	Physician /Medical Examiner	er	23a. Part1. Enter the disease or compance, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	one cause on each line.) (e nce of):	er the mode of dying				Approximate Interval Between Onset and Death
68/60,	death certificate be executed e attending physicien and id for use as the burial-transit	Medical Examin	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c						
.O. Box	0 0	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
cords, r	requires that the neen signed by th hould be detache		Part II. Other significant conditions co	ntributing to death but not resultin	ng in the un	derlying cause give	on in Part I.	23e. Did to	bacco use contribute to es 2 No 3 □ Pro	the cause of death?
Ž.	The la ate has page 2	e Completed	25. Was case referred to medical						med? death? 2 ☐ No 1 A Yes	opsy findings available ompletion of cause of
	Physiclan: r this certific ral director,	ToB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/	/Outpatient	3□ DOA Othe	_	th <i>Check only</i> on	ence 6 QOther (Spec	fv) (~~~~~)
10 U	ing Pt Viter th Ineral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	ow injury occurred	- (Malle)
DIVISION	ttendi death ctor: / the fi	icati	2 Accident investigation 3 Suicide 6 Could not be		10.21		es 2 ŽNo		yectshot	
2	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	il Certification:	4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - At home building, etc. (Specify)	2 6	t		Fing , IV	Ave Ft. Wis	renton MD
	Ne Hos	edical	(Check only one)	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	red at the time, d	ause(s) and manner as a ate and place, and due t	stated. o the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier	allavard		29c. License O.C.M			9d. Date signed (Month, August 27,	
	3		30. Name and address of person who co	ompleted cause of death (Item 23	Ba) (Type, F		enn Stre	et, Balt	imore Maryl	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature		400				

Registrar DHMH 17 Rev 1/2001

SEP 0 6 2005

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #9821 PER FH G84 Pertificates of Peath Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year August 25, 2005 Elaine Barbara Billhimer 8:31 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 20, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 10 M 20 F 59 MARYLAND Director 216-44-0232 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1 √2 Yes 2 □ No Directo Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1349 Huntover Drive or Itema 23a 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Year or Dates: White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within tof Health and Mental Hygiene. If Item 27 is marked other than " Elementary/Secondary (0·12) 12th College (1-4or 5+) Cashier Restaurant/Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George John Otto Regina Mauhausen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Billhimer, Sr./spouse 1349 Huntover Drive Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any njury or oti 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) West Arundel Crematory 8/31/2005 Odenton, Maryland -DVR 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. JUANITA R. THOMAS M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) /Medical **Examiner** Pulmonary FILTOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of burial-transit Due to (or as a consequence of): attending physicien Box 68760 pg Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy No 1 ☐ Yes 2 ☐ No 1 Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 24 hours after de Funeral Directo letely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1D/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) Medi within 2 To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0053393 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Kd Odentu, Ms assur Ann Frika 1132 PO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SEP 0 2 2005

			1- For State of Maryland / Department of Health and N Certificate of Death		ene 2005	28826
	Physici		1. Decedent's Name (First, Middle, Last) TDA M. Cutchin	2. Date of Death Month Leptenber		3. Time of Death 12'.20A7M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	200100	4c. County of Death	
			KESWICK MUlti HEDICAL CONTER Balt HORG 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	NIA	John China a Carrie
H	Funeral Director		241366450 1 M 2 F 80 Yrs. Months Days Hours Min.	(Month, Day,	Year) Col	iplace (State or Foreign intry)
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	hours after death with the Marylar turel', or Itema 23a or 28a-1 show at Examiner must be motified at	Director	macyland N/A BALTIMOVE			1 Yes 2 □ No
	with the		10e. Street and Number 4 212 10f. Zip Code 21201	10	g. Citizen of What Cou	untry?
	death ma 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Society of Hispanic Origin?)	ecify Yes or No-	USA 14. Race - Amer	
9	s after , or Ite	by Fur	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify	Rican, etc.)	Black, White	
15-0036	within 72 hours after death with the Maryland ene. then "neturel", or Itema 23a or 28a-1 show f.s M-dical Examiner coust be notified at	ted b	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	11	Specify; B (a. 6b. Kind of Business/I	c k ndustry
212	f within 72 ho liene. r than "natur the Medical	Completed	(Specify only highest grade completed) [Give kind of work done during most of works life. DO NOT use ratired) [Give kind of work done during most of works life. DO NOT use ratired)	G	reaker BA	LTIMORG
7 0	be filed w ta! Hygier d othar ti		12 th grade Nurse Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name			GNTUC
/land		To Be	Ractoro Thompson Theous			
Mary	12 should h and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	I Route Number,	City or Town, State, Zi	p Code) 2/239
	s 1 and if Health itam 27 othar to		20a. Method of Disposition Drough From State 20b. Place of Disposition (Name of Commetter, crematory of other place)	Date 20	It KOKE N	own, State
Baltimore,	8°= 5					
Salt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility C N 1			
	707 e 0		23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			
	Physician	_	shock, or heart failure. List only one cause on each line. + Immediate Cause (Final	r respiratory arres	it,	Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death) Due to (or as a consequence of):			Syears
	Examiner	- in	Sequentially list conditions, b. Due to (or as a consequence of):			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate dates. Enter Underlying Cause (Disease or injury that initiated events			
Ď,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):			
09/89	ficate t	edical	d			
ZOZ	th certi lending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of deliv	,
о П	the death certificate be executed y the attending physician and tched for use as the buriat-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Head of death 5 □ Other (specify)		Month	Day Year
7	wrequires that the de been signed by the s should be detached	by Ph	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	he cause of death?
cords,	requires that een signed b nould be deta		Diabetes mellisers, type II	1 🗆 Yes	2 No 3□ Pro	bably 4 Unknown
Č	The law rate has be page 2 sh	Completed		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
VII		e Co	25. Was case referred to medical 26. Place of Death	1 Yes 2	No 1 □ Yes	2000
01 0	hysician: nis certific I director,	To B	examiner?		ce 6 □Other (Speci	(y)
	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe how		
UNISION	Attanger death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or Run	al Route Number,
5	ital or rrs efte ral Dir	Cert		City or Town,	,	
	To the Hospital or Attanding Physician: To the Funaral Director. After this certific completely filed in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of my knowledge, death occurred at the time, date and place, a construction one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau ed at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)
	To T To T	Σ	29b. Signature and title of certifier M. Babelle Mac Gregor M.D. 29c. License number 29c. License number D 13657		Date signed (Month,	
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type Print)			
. `			VI SABELIE VIALYREGOR, 700 W. 404h STREET, BALTI	MORE,	7021211	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6 2005			
		1,00	OLI II U LOUS MASSIVE POR CONTRACTOR OF THE CONT			

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>		of Health and of Death		ene 2005	28827
	Physic /Medi		1. Decedent's Name (First, Middle, Last Dale Richard Col					2. Date of Death Month 08	Day Ye 30	3. Time of Death 05 03:20a M
	Examir		4a. Facility Name (If not institution, give 7424 Brickyard Re)		vn, or Location of Dea OMac		4c. County of E	
	Funeral Director		203-30-1410	x 7. A	ge (In yrs. last birthday, 62 Yrs.	If Under 1 Y Months Da	ear If Under 24 Hrs ays Hours Min		9. 1942	Birthplace (State or Foreign Country) Ohio
	e Marylend 8a-f show tiffed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Montgot	mery	10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 █No
	with the	Dire	10e. Street and Number 7424 Brickyard Re	1		10f. Zip Co	20854	10	g. Citizen of What	Country?
036	be filed within 72 hours after death with the Marylend tal Hygiene. Id other than "naturel", or items 23a or 28a-f show event, the Medical Evarring must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No		of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A	merican Indian, White, etc. White
Maryland 21215-0036	e filed within 72 ho al Hygiene. other than "natur vent, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 8+	5+) (Give		one during most of wo etired) f Human Re	sources		erment
and		Be	17. Father's Name (First, Middle, Last) George Collins					me (First, Middle, M Brown Co		
Mary	12 sh h and 7 is m traum	2	19a. Informant's Name/Relationship (7) Lisa Shea/wife	уре, Print)			reet and Number or R	ural Route Number,		e, Zip Code)
Baltimore,	t ter		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ f 1 □ Donation 5 □ Other (Specify,		20b. Place of Disponentery, cre Chesapea	matory or other	place)	Date 2 -01-2005	Oc. Location - City Beltsv:	or Town, State
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	Runcum	M00382 2	Rapp :	ddress of Facility Funeral & ist Ave Si			910
	Medical Examiner buysician and buysician and physician land strength buysician and strength	dical Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	of the death. Do not en ine. Creas Cance s a consequence of): s a consequence of): s a consequence of):		dying, such as cardia	c or respiratory arres	st.	Approximate Interval Between Onset and Death 4 months
.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregna			23d. Date of Month	delivery Day Year
Q	ires that signed b	by	Part II. Other significant conditions co	ntributing to death t	out not resulting in the u	nderlying cause	given in Part I.			o to the cause of death? Probably 4 □Unknown
al Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform	prior ed? death	autopsy findings available to completion of cause of ? es 2 \(\text{No} \)
Vital	Physician: This certificatal director, p	o Be	25. Was case referred to medicał examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpati	ent 2 ER/Outpatie	nt 3 DOA	Othor	ath <i>(Check only one</i> Iome 5 %R esiden		posific)
Division of	i or Attending Phy after death. Director: After thi I in by the funeral of	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	28b. Time of Injury	f 28c. I	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how 28f. Location (Stre	injury occurred	Rural Route Number,
á	Hospital or 4 hours afte Funerel Dir ely filled in l	ledical Cert	29a. Certifier 15 Certifying Phy (Check only 2 Medical Exami	sician: To the best	tc. (Specify) of my knowledge, deat of examination and/or in	h occurred at th	e time, date and place	City or Town, a, and due to the cau	se(s) and manner	as stated.
1	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	and manner st	tated.	29c. Lic	ense number		d. Date signed (Mo	onth, Day, Year)
	13		30. Name and a dress of person who con Leon Hwang 1396			Print)	D45880		08-31-20	303
K	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 6 20		rar's Signature					

			1 → For State Registrar	State o	f Marylar		artmen rtificat			and M	lental Hyg	giene Reg. No	20	05	28	828
	Physici		1. Decedent's Name (First, Middle Clementina	Cuomo							2. Date of Dea	ath		rear	3. Time of 10:17	
	/Medio Examir		4a. Facility Name (If not institution, 1140 Greenacr	give street and nur e Rd.	nber)		4b. City, TOWS		Location of	of Death	-	4c.	County of	Death More		
	Funeral Director		5. Social Security Number 216-74-2070	6. Sex 1 □ M 2 🛣 F	7. Age (<i>In yr</i> s. 92	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Decorth, 10a	h Yeard	912	9. Birthp	lace (State o	r Foreign
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Md. Balti	more	_	y, Town or Lo	cation							1	0d. Inside Ci	
	s with the	i Director	10e. Street and Number 1140 Greenacr	e Rd.	· · · · · · · · · · · · · · · · · · ·		10f. Zip	Code 2128	36			10g. Cît	izen of Wh	nat Coun	,	
036	2 should be filed within 72 hours after death with the Maryland and Mentel Hyglene. Is marked other then "naturel", or Iteme 23a or 28a-f ehow aumatic event, the Medical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Dece Armed Fo	2 🔁 No 'e		Was Deced f Yes, spec 1 ☐ Yes		spanic Origin, Mexican		acify Yes or No- Rican, etc.)		14. Race Black, Specify:	- Americ White,	an Indian, etc. White	
Maryland 21215-0036	d within 72 ho glene. rr then "natur tra Medical I	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)		-4or 5+)	16a. Deced (Give life. L Homen	kind of wo. DO NOT us	al Occupa rk done d se retired	ation furing most)	t of worki	ing		ind of Busi		lustry	
land	should be filed and Mentel Hygle s marked other umatic event, in	To Be C	17. Father's Name (First, Middle, L Felix Rescig						18. Mothe Mar		<i>(First, Middle,</i> Panico	Maiden	Sumame,			
, Mary	and 2 sho lath and h n 27 is ma er trauma		19a. Informant's Name/Relationsh								d. Luth					3
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🛣 Other (Sp	3 □Removal from :	State	Place of Dispo cemetery, crem laney	natory`or o	ther place	´ 1 [9 - 6-(Date D5		i moni	•		
Balt	permit. Depertr Importe any Inje		21. Signature of Funeral Service L	icensee)		22	RUES	d Addres IOW YOT	8 Facilit	uper Tow	al Home	. I	204			
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	-a. Po	aused the deat ach line. Or as a conseq	eati	1		g, such as		or respiratory ari	rest,			Approximate Interval Bety Onset and D	veen
8760, 1	ficate be executed XX physicien and XX is the burial-transit	ai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	or as a conseq or as a conseq											
	ath certi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		come of pregna irth 2 □ Feta ant at time of d	Ideath 3	Ectopic pr						23d. Date		•	'ear
о. О.	0 0	Physic	in the past 12 months? 1 Yes 2 No 9 Unknown	9□ Unkno	own		Other (sp				00. 2:44					
Records,	law requires that the as been signed by th 2 should be detache	ρ Σ	Part II. Other significant condition	is contributing to de	sath but not res	uiting in the ur	naeriying c	ause give	en in Paπ i.			es 2		ute to th ☐ Proba	e cause of dealbly 4 U	
_	The ete h page	Completed									24a. Was a autop: perfor 1 \(\t \) Yes	sv	pride	or to con ath?	osy findings a apletion of ca 2 No	available luse of
Division of Vital	I or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner? 1 Yes	28a. Date of (Mont	of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	at 4 □ Nu	rsing Hor	ne 5 Resid	ence (ow injur	y occurred			
<u> </u>	pital or Al		4 Homicide determine	ned 286. Place buildir	of Injury - At he	y) ~					28f. Location (S City or Tow	n, State)			oer,
	To the Hoepital of within 24 hours at To the Funeral D completely filled in	Medical	one)	Physician: To the xaminer: On the ba and mann	isis of examina	tion and/or inv	estigation,	in my op	oinion, deat	d place, a th occurre	ed at the time, o	late and	l place, an	d due to	the cause(s)	
)	7 × 5		29b. Signature and title of certifier A. C. M.	rolle	- M.	D.		License	14	182		9	e signed (10	5	
	7		30. Name and address of person v	e, M.D.	7505 0	sler D	Print) r. #3	05 T	owson	ı, Mo	1. 2120)4				
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6	100	egistrar's Signa	iture	and I									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - State Registrar 28829 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month CARTER HUDREY 2005 12", 35;M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOUR HOSPITAL BALTIMORE CITY 130 N N/A If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2X F Director 212-48-8805 85 Yrs. 04/25/1920 MASSACHUSETTS Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at BALTIMORE CITY 1X Yes 2 □ No MD N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 WOODINGTON ROAD 21229 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give* Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. e filed within 72 hours after all Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo þ Specify: BLACK 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 12TH permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic event, 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT POOLE WOODSON EDITH W. HENDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRETA A. YOUNG / DAUGHTER 3710 HARLEM AVENUE, BALTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State 9/9/05 BROOKLYN PK, MD CEDAR HILL CEM. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral 4600 LIBERTY HEIGHTS AVE, BALTIMORE, men 23a. Part i. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one daust on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RENAL Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PARKINSONISM Sequentially list conditions, 1 any leading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dehydrahon 1 Yes 2 No 3 Probably 4 Minknown leted peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl autopsy performed 2□ No 2 No 1 Yes 1 Tyes 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending P. 24 hours after death. e Funeral Director: After the 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D001966 A. M. Show No <h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balnmore, MD Hospital R.M. SHAHMO Bu lected Course 31. Date filed (Month, Day, Yes)

State

Registrar

English and a

an Registrar's Signature

			1 - For State of Ma		artment of Health and M	fental Hygien	2005 20031
	Physici		1. Decedent's Name (First, Middle, Last)	ness		2. Date of Death Month D September	3. Time of Death 3. 2005 S'30 PM
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	/C	4b. City, Town, or Location of Death	3-7.0	c. County of Death
	LAGIIII		Washington Adventist He	ospital	Takoma Pa	rK	Montgomery
	Funeral Director		229-86-5290 10M 2015	(In yrs. last birthday) 47 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea September 18 1	9. Birthplace (State or Foreign Country) Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	he Mary	Director	Virginia Fairfax	Great			1 ☐ Yes 2 🗷 No
	th with t 23a or 2 181 be n	al Dir	10211 McKean Court		10f. Zip Code 22066	10g. C	Citizen of What Country?
36	72 hours after death with the Maryland naturel", or Hems 23e or 28e-1 show Jest Examir se must be notified at	by Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 Nover Married 2 Married 1 Pes 2 Nover Married 3 Widowed 4 Divorced 14. Was Decedent E Armed Forces? 1 Pes 2 Nover Married 1 Pes 2 Nover Married 1 Pes 2 Nover Married 1 Pes 2 Nover Married 1 Pes 2 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 2 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 1 Pes 3 Nover Married 2 Nover Married 1 Pes 3 Nover Married 2 Nover Married 1 Pes 3 Nover M	0	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
15-0("natural",	ieted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
212	be filed within 72 ho ital Hygiene. id other than "natur event, Ire Missical	Completed	Elementary/Secondary (0-12) College (1-4or 5+	·) //	Accountant Ar	alyst	SAIC
Maryland 21215-0036		To Be	17. Father's Name (First, Middle, Last) Clay Cabiness		18. Mother's Name Edit	e (First, Middle, Maide H Won	,
lary	2 sh and lam aum		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Rura	al Route Number, City	or Town, State, Zip Code)
	s 1 and if Health item 27 other tr		Sandra F. Eskridge - Sister	/0211 20b. Place of Dispo	McKeun Court Gre		
Baltimore,	0 0		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	cemetery, crei	matory or other place)	1	Lothtion - City or Town, State
altin	artra orta inju		4 ☐ Donation 5 ☐ Other (Specify)21. Signature of Funeral Service Licensee		Memorial Park 9/7, 2. Name and Address of Facility	105 A	nnandale, Virginia
ä	Dep Impo		Robert B. Baker	fr. CI	hinn Funeral Service 21	1055. Shirling	thin Rd Arlington, Va. 22206
П			23a. Part ¹ . Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	the death. Do not ent	ter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	PS15			Onset and Death
	Examiner		Due to (or as a	ongequence of):	140		
	b ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	1112		
_	xecute and II-trans	Examine	that initiated events	consequence of):			
8760,	cate be executed physician and the burial-transit		d				
9	rtificate ng phys as the	Medi	IE CENALS.				
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	sign sign d be	by	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecol	aw Is b	Completed	Oncoma 10 paths	Sei 30	ine disorder	24a. Was an autopsy	24b. Were autopsy findings available
E E	Th ate pag	Com				performed?	prior to completion of cause of death? 1 Yes No
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sior	Attending I r death. ector: After by the funer	atio	2 Accident investigation	Year) Injury	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta.	nd Number or Rural Route Number, fe)
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the basis of earth manner state	examination and/or in	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(ed at the time, date ar	s) and manner as stated. Indiplace, and due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and titlejof certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
	1		- July Way	1.4.2	D4547	Li	7/3/03
()	55.	30. Name and address of berson who completed cause of deal of the VS.	ath (Item 23a) (Type, SIE M- 1	2 Withhal	n Ani	untich HOSE
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registral SEP 0 6 2005	's Signature	1.4.	7100	11 11 11
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State of Maryland / Department of Health and Mental Hygien 2005 28831 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 30. JOSEPH RICHARD 1355 2005 COOK /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NA JOSEPH RITCHIE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**M** M 2□ F Yrs. Director 213-20-8430 08.30.1926 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f ehow other treumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 N. SMALLWOOD STREET 21223 USA or iteme 23e Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Year or Dates: naturel Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other then Elementary/Secondary (0-12) College (1-4or 5+)

• YRS Hygiene. ADMINISTRATOR BALTO. CITY SCHOOLS 1214 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi Be NEIL PARHAM ELLA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent; If item 27 is m eny injury or other treum QDGE. WIFE) REBECCA COOK ST. BALTO MA 102 N. SMALLWOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) bate 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) GARRISON FOREST 09.07.05 OWINGS MILLS. 21. Signature of Fune al Service License VAUGHN C. GREENE PUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONO /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performe 21 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Special 1 ☐ Yes 2000 No 2 Ke this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After To the Hospitel or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6301 N CHALLES ST. BALTIMORG MD IGLEHART TUND W 2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 28832 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 4, **Physician** ^{Yeer} 2005 SANTO JOHN CONIGLIARO 2:44a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 812 OLD HARRIS MILL ROAD MARYLAND LINE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 219-26-62147. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2 F Yrs. 1938 MARYLAND Director 67 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercit er must be notified at MD BALTIMORE MARYLAND LINE 1 Tyes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 812 OLD HARRIS MILL ROAD or Itams 23a 21105 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after d il Hygiene. other than "natural", or Itam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If item 27 is marked other tha any injury or other traumatic event, Item 2006. INSULATION CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL CONIGLIARO SARAH RUSSO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLAND LINE 19a. Informant's Name/Relationship (Type, Print) 812 OLD HARRIS MILL ROAD, MARYLAND 21105 JUDITH CONIGLIARO wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Daurial 2 ☐ Cremation 3 ☐ Removal from State PINE GROVE SEPT. 9, 2005 RAYVILLE, MD. ' 4 □Donation 5 □ Other (Splecity) 21. Signature of Furery Lervice 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK ROAD, MONKTON, MD 21111 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician 2-3 months resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Univerlying Cause (Disease or injury that in the cause) Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by tage Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 1 Yes 2 No fo the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes SNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After thi funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. uneral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral D filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D16587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Oslen Towar, MO 21204 Chano 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

			For State Ragistrar	State of Maryland	-	artment or tificate			lental Hy	giene Reg. N200	5 288	33
	Physici	an	Decedent's Name (First, Middle, Last						2. Date of De	ath	3. Time of De	eath
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	and DW		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation					10d. Inside City	Limits
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	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Items 23e or 28a-1 show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 4510 Puller Dr.			10f. Zip Co	ode 0895			10g. Citizen of Wha	t Country?	
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	1 ar		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name natory or othe	of	-	Date	20c. Location - City		
imo	Pages nent of I ent: If its ury or o		1 🖾 Burial 2 □ Cremation 3 □ F `4 □ Donation 5 □ Other (Specify)			Cremato		09-	04-05	Baltimor	e, MD	
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	5		30. Name and address of person who co	~	_	Print)				100 01	2-1-2-40	
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4 5	Physici			, Allison El	lizaba	eth Ca	aldwe	<u>-</u> 11		S	Month Septemb	er I	200	ear)5	3. Time o	р Р М
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	artmer ortant: Injury		4 □Donation 5 □Other (Specify 21. Signature of Poneral Service License			ro Cre				9 – 2–2	D-		nsvil			-
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			1- State of Maryland / Dep	partment of Health and Nertificate of Death		iene 2005	28835
	Dhysisi	0.00	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medic		Joseph F. Cavey, Sr.		August	31 2005	5:45P [™]
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Francis	-	124 Winter Harbor Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Ocean City If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Worceste	
	Funeral Director		212-07-6442 ^{1⊠M 2□F} 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, June 25	1920 M	place (State or Foreign intry)
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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	the A 28a-1 notiffi	Funeral Director	MD Worcester Ocean C	1 ty 10f. Zip Code	10	g. Citizen of What Cou	
	3a or	Di	124 Winter Harbor Dr.	21842		USA	indy.
	ems 2	ner		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
98	or Ite	y Fu	1 ☐ Never Married 2X Married 1X Yes 2 ☐ No. 1 I	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Specify: White	
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow deat Examinar must be notified at	ed by	Tour or Builds.	edent's Usual Occupation	1.	6b. Kind of Business/li	
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nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Ma		
Maryland 21215-0036	d Men narke natic	²	William Cavey		th Barber		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, If e Medical Examinar must be notified at once.		21. Signature of Funeral Service Lipensee	22. Name and Address of Facility Har:	ry H. Wit	tzke's Fam	ly FH Inc.
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ħ,			23a. Part1. Enter the disease, or complications that caused the death. Do not enshot, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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Division of Vital Records,	or At after of Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
_	spital		29a. Certifier 1 ☐ Cartifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cau	ise(s) and manner as s	tated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the tuneral director.	edicai	(Check only one) 2 Madical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	e and place, and due to	the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
•	1		Anothy C. Holganth M.D.	D06241		9-1-05	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type		. An i	3.010	
	Sta	te.	DOROTHY C. HOLZWORTH M.D. 20 31. Date filed (Month, Day, Year) 2. Registrar's Signature	3 SNOW St. SNOW +	TILL, /Ild	1, <1863	
	Registra		31. Date filed (Month, Bay, Year) SEP 0 6 2005	where the same of			

			For State of Maryland / Depar	rtment of Health and l rificate of Death	Mentai Hygie Reg.	2005 28836
	Physici		1. Decedent's Name (First, Middle, Last) Lillian Lucinda Davis		2. Date of Death Month	Day Yeer 3. Time of Death
	/Medic Examin			4b. City, Town, or Location of Deat	Aug. 25	4c. County of Death
	Lxumm	ŭ,	Milford Manor Nursing Home	Pikesville		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		217-34-4924		June 25	,1936 Maryland
	yland how		10a. State 10b. County 10c. City, Town or Loca			10d. Inside City Limits
	Ba-fs	Director	Maryland N/A Baltin			Yes 2□No
	with the	Dire	10e. Street and Number	10f. Zip Code 21215	10g.	. Citizen of What Country? Usa
	Jeath ns 23		3800 W. Belvedere Avenue #1127 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puen	Specify Yes or No-	14. Race - American Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ita Medical Eve cities instituted at once.	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No	Yes, specify Cuban, Mexican, Puerl ☐ Yes 2 No <i>Specify:</i>	to Rican, etc.)	Black, White, etc. Specify: Black
2	72 hc 'natur	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	ont's Usual Occupation ind of work done during most of wo O NOT use retired)	rking	b. Kind of Business/Industry
12	within ane. than	mpi	Elementary/Secondary (0-12) College (1-40r5+)	onoruse retired) eter	7	vertising Distri- tion Co.
2	filed Hygid other ent,	Be Co	7th grade 17. Father's Name (First, Middle, Last)		me (First, Middle, Mai	
<u>la</u> n	uld be Aental rked tic ev		Leroy Jackson	Re	gina Joh	nson
lar)	2 sho and h is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Ru	ural Route Number, C	ity or Town, State, Zip Code) 21215
	1 and Health Health Hear 11		Robert Davis/ Husband 3800	W. Belvedere	Ave- Bal	timore, Maryland Location - City or Town, State
nor	ages ant of it: If its y or o		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 20b. Place of Disposic cemetery, cremated crownsvil	le Vet. Cem.	/05 Cro	wnsville, Marylan
Baltimore,	mit. F partme portan / injur	1				arris Funeral Home
<u>~</u>	permi Depa Impo any ir		Juy Faris 52	40 Reistersto	wn Rd Ba	arris Funeral Home 1timore,Md 21215
		-	23a. Part. Enter he disease, or complications that caused the death. Do not enter snock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician (/Medical		Immediate Cause (Final disease or condition resulting in death)	montia		0,10, 1,12
	Examiner		Due to (or as a construence of):			
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	ecute and trans	Examiner	Cause (Disease on injury that initiated events c			
68760,	tificate be executed ig physician and as the burial-transit	E	Bus to (or as a consequence of).			
687	tificate g phys as the	ledical	Q			
XO	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy		23d. Date of delivery
P.O. Box	The law requires that the death cert ate has been signed by the attendin bage 2 should be detached for use	Physiclan/N		Other (specify)		Month Day Year
	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	w requires to been signer should be a	ed by			1 ☐ Yes	2 No 3 Probably 4 Unknown
000	ne faw re thas bee ge 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The cate h	Соп			performed 1 ☐ Yes 2 ☐	death?
Vital	Physician: Th r this certiticate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Cthon	ath (Check only one)	
ō	p Phys er this eral di	J: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	fome 5 Residence 28d. Describe how i	e 6 Other (Specify) injury occurred
ion	Attending I r death. ector: After by the tuner	atio	1 DNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division of	l or Attendatter death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, State)
	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	accurred at the time, data and place	and due to the caus	o(e) and manner as stated
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegored and manner stated.	stigation, in my opinion, death occu	urred at the time, date	and place, and due to the cause(s)
1	To the within To the comple	Σ	29b. Signature and title of certifier	29c, License number H45737		Date signed (Month, Day, Year) AVSVIT 30 (2005)
	HI		30. Name and address of person who completed cause of death (Item 23a) (Type, Power Land Control 200 Power (1994) 31. Date filed (Month, Day, Year) SEP 0 6 2005	ils Diene	Beltimo	August 30, 2005 ne MO 21208
	Sta		31. Date filed (Month, Day, Year) SEP 0 6 2005 32. Refistrar's Signature	tout !		
	Registr	ar	OLI VI EUUS JURGINE JU JA		·	

		,	For State Registrar	State of Maryland	/ Department of He Certificate of L		I Hygiene 2005	5 28837
	Physici /Medio	cal	1. Decedent's Name (First, Middle, I	Alph Dyer	SR.	Auc	gust 25 200	15 4:20 AM
	Examir Funeral Director	ier	4a. Facility Name (If not institution, s CIVISTA Med 5. Social Security Number 6 218-34-6544	ical Center. Sex 7. Age (In yrs. las	4b. City, Town, or APA+ st birthday) If Under 1 Year Months Days	4	4c. County of De Ch AR e of Birth nth, Day, Year) 9. 8	irthplace (State or Foreign Jounty)
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MARCI And Ch A	Kles 10c. City,	Town or Location LAPIATA			10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28i ist be not	ai Director	10e. Street and Number	HA ROAL	10f. Zip Code	16	10g. Citizen of What (Country?
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinat must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, e Specify:	s or No- etc.) 14. Race - Ar Black, Wh Specify:	1 1 1
2121	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, fre Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest the Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	16a. Decedent's Usual Occupa (Give kind of work done diffe, DONOT use retired)	uring most of working	5eif-en	1 /
yland	should be fill and Mental His marked oth	To Be	17. Father's Name (First, Middle, La	A. Queen		18. Mother's Name (First, I MARY O	. HAWKIN.	5
ore, Mary	0 0		19a. Informant's Name/Relationship 20a. Method of Duposition 1 ™Burial 2 □ Cremation 3	er/WiFe	19b. Mailing Address (Street a.	AtA Rd. LA	Number, City or Town, State 20c. Location - Care	And 20646 or Town, State
Baltimor	permit. Pag Department Important: I any injury o once.		* 4 □ Donation 5 □ Other (Spe 21. Signature of Fuheral Service Li		Cred HEART 22. Name and Address 11 Adams Fu	108/30/03 s of Facility Neral Home	5 KAPIATA, 1 Aguasco. Ma	MARY IAND DULAND 20688
	Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death. It one cause on each line. a	sy	, such as cardiac or respira	atrest,	Approximate Interval Between Onset and Death
,	Examiner payable by executed by sicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First things of the cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque	hour	el des	ease.	
68760	ificate be g physicie as the bur	dical		d. gentre	intestina	l ble	J	
.O. Box	The law requires that the death certificate be executed tale has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of d Month	elivery Day Year
<u>α</u>	w requires that the been signed by should be detact	by	Part II. Other significant conditions	s contributing to death but not result	ing in the underlying cause give	n in Part I. 23e	a. Did tobacco use contribute 1 ☐ Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
of Vital Records,		Completed	chiery	we, ale	me of			autopsy findings available completion of cause of as 2 No
f Vit	S S	To Be	25. Was case referred to medical examiner? 1 ▼Yes 2 □ No	Hospital: 1 Inpatient 2 E	R/Outpatient 3□ DOA Othe	26. Place of Death (Check r: 4 ☐ Nursing Home 5 ☐	conly one) ☐ Residence 6 ☐ Other (Sp	ecify)
Division of	ding h. After fune	Certification: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could no	(Month, Day Year)		at 28d. Des ? es 2 □ No	scribe how injury occurred	
Divi	tal or At rs after or al Direct ed in by	Certif	4 ☐ Homicide determine		e, farm, street, factory, office		ation (Street and Number or I or Town, State)	Hural Houte Number,
	To the Hospital or Attenswithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my knowled mainer: On the basis of examination and manner stated.	edge, death occurred at the time in and/or investigation, in my op	e, date and place, and due inion, death occurred at the	to the cause(s) and manner as time, date and place, and di	as stated. ue to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	1 - 11 11	29c. License	number	29d. Date signed (Mor	nith, Day, Year)
	4		30. Name and address of person we	no completed cause of death (Item 2	(Type, Print) 8 LAG(Ange	Ave. LAPlata	Md. 206	46
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Figistrar's Signatu	& Species	1:4.1.0		

State of Maryland / Department of Health and Mental Hygien 2005 28838 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Karen D. Dinen 22,14 M 09 04 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F 215 543 188 50 Director 29, 1954 Maryland Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examinar must be notified at Funeral Director 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8720 Emge Road Itams 23a 21234 USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not any injury or other traumation." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse 12 Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon G. Walsh ျှ Regina G. Johansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3657 Keystone Avenue Baltimore, Maryland Regina Harris Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 09/07/2005 Pikesville, Maryland 21. Signat re of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland shock, or Meart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Examiner Renal disease stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Pes 2 No 23d. Date of delivery atter for L 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one! Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After s after dec. ral Director: After hy the fu 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier Res 000 09/04/ 5601 Loch Raven Blud, > Souzdalnitski 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Souzdalnitski, Dr. Dmitti 31. Date filed (Month, Day, Year) SEP 0 6 2005 32. Registrar's Signature State Registrar answer !

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of He	ealth and Mental Hygiene 2005

		1 - State Registrar		Cer	tificate of L	Death	Reg. N	lo.	20000
Physici	an	Decedent's Name (First, Middle, Last)	HARLES	DYSO	N		2. Date of Death Month	ay Year	3. Time of Death
/Medic	al	4a. Fecility Name (If not institution, give street		0130		Location of Death	W F, W	29 2005 lc. County of Death	1:17 PM
Examin	er	Greater Baltimore		Center		owson		Baltim	
Funeral	Š.	5. Social Security Number N 6. Sex		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day, Yee	r) COL	plece (State or Foreign intry)
Director		Usual Residence of Decedent				1 75	August 29,	2009	MANY LING
aryland show	_	10a. State 10b. County		City, Town or Loc		./			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the Mi	Director	MANYANO BALTIMO	RE	Winds	10f. Zip Code	//	10g. (Citizen of What Cou	
3a or		7505 Lexham	COURT	-	213	244		USA	
oms 2	Funerai	A A	as Decedent Ever in med Forces?	U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Span, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Raca - Amer Black, White	
hours after deeth with the Maryland hours after deeth with the Maryland ture!, or Items 23s or 28s-f show at Examiner must be notified at	by Fu		☐ Yes 2 ANo Yes, Give ear or Dates:	1	☐ Yes 2XNo	Specify:		Specify:	MACK
72 hours "naturel",	eted	15. Decedent's Education (Specify only highest grade con		16a. Deced	ent's Usual Occupa	ation during most of works		Kind of Business/li	
Mithin 7	Completed		ollege (1-4or 5+)	life. C	OO NOT use retired	NIA		NIA	
be filed within 72 tal Hygiene. d other than "nai	Be Co	17. Father's Name (First, Middle, Last)	10 173			18. Mother's Name	(First, Middle, Maid	en Sumame)	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Men	To B	Christopher		DYSO	N	Timil	KA	1/2.	TES
s 1 and 2 should be filed within 72 he filed and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, the Medical		19a. Informant's Name I lationship (Type, F	· .	19b. Mailin	N- CHAR	LESST.	I Route Number, City	or Town, State, Zi	p Code) -04
permit. Peges 1 and in portant. Peges 1 and inportant: If item 27 any injury or other tr		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Remo	20b	. Place of Dispos cemetery, crem	sition (Name of natory or other place	0)	100	Location - City or 1	own, State
Peges tment of tant: If it		4 □ Donation 5 □ Other (Specify)	67	REEN	MOUN"		005	LIMORE	MD
permit. Pe Departmer Important: any injury		21. Signature of Funeral Service Licensee)	16	/	ss of Facility F	MONKTON,		10 SONS CO-
		23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the de	eath. Do not ente	1-		-	, , ,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Extre	me 14	Ve Ma	twriti	1 224	17	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cons	equenca of):			Mes	いつ	
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
ecuted and transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	aguages of):					
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ug physas the	Medical	0.							
ath cer		zob. vvas decedent pregnant	yes, outcome of pred □Live birth 2 □F	etal death 3∟	Ectopic pregnancy			23d. Date of deline	very Day Year
the de	Physician	1 Vac 2 No	☐ Pregnant at time o ☐ Unknown	iideaun 5	Other (specify)			8	27 2005
ss that gned b	by Pl	Part II. Other significent conditions contribu	ting to death but not	resulting in the ur	nderlying cause give	en in Part I.			the cause of death?
require een si	peted						1 🗆 Yes		obably 4 Unknown
ne law has b	Completed						24a. Was an autopsy performed	prior to o	topsy findings available ompletion of cause of
cien: Ti cien: Ti ertificate ector, pa	a	25. Was case referred to medical				26. Place of Death	1 Yes 2 7	No 1 □ Yes	2 No
hysici his cer I direc	To B	examiner? 1 Yes 2 No	tal: 1 Inpatient 2	☐ ER/Outpatien		4 140/5/19 110	m <i>e</i> 5 ☐ Residence		ufy)
l or Attending Phy after death. Director: After this in by the funeral or		1 ☑Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe how in	ijury occurred	
Attender deatler deatler by the	Certification:	2 Could not be	Be. Place of Injury - A building, etc. (Spe	t home, farm, str			28f. Location (Street City or Town, St	and Number or Ru	ral Route Number,
Itel or raf Dir led in	Cert								
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of my l On the basis of exam and manner stated.	knowledge, death ination and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	ed at the time, date a	and place, and due	to the cause(s)
To the To the comp	Ž	29b. Signature and title of certifier)N	1-D	29c. Licens	9 number 938719	29d.	Date signed (Month	, Day, Year) - 2005
		30. Name and address of person who comple			Brint)	+ 2 11	'M.O. M	1 212	- 2005 04
S.	ate	Sabah Helow, 31. Date filed (Month, Day, Year)	32. Registrar's Si		res sjik	el, valli	mace 111	DZ.	
Regist		SEP 0 6 2005	A serie	H de	relis				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John Elder august 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner county General Hosp Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Day 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 227-62-424 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21045 USA items 23a Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 þ Blac 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) sabled Mother's Name (First, Middle, Maiden, Symame) Be 19b. Mailing Address (Street and Number or Rura Department of Health a Important: if Item 27 is sny Injury or other tree QRG®. lumbra, MD 21045 20a. Method of Disposition 20b Place of Disposition (Name o. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Si maure of Fugeral Service License Funeral Services 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by enorvena cava 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 20 No 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifies 29c. License number D50870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIZON Abdo 5005 Signal Bell Cane Clarksville MD Bell 32 Registrar's Signature 31. Date filed (Menth. Pay (Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 31, Lamar Joseph Fortman, Jr. 2005 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAR 18, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 XM 2 ☐ F Director 63 213-40-0366 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Iteme 23a 600-A Carrollwood Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Iteme 23s eny injury or other treumatic event, the Medical Examiner manageness. 21220 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0·12) Recycling/House College (1-4or 5+) Laborer/Painter Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lamar Joseph Fortman, Sr. Winona Alma Hand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony T. Fortman/Son 1275 Neighbors Avenue Baltimore, NO 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/3/05 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disbase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of): Examiner MALNUTRITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day P.O. | 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ should ! Completed 1 Yes 2 🗌 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62388 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENHAESE, D. 76/21 [32. Reg trar's Signature DIANE OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) State SEP 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygienes 28842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Francis E. Federline 5:45 P™ 2005 4, September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 8, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2□ F 93 Yrs. 578-32-5517 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant; If item 27 is marked other than "natural", or Itams 23a or 28a-1 show injury or other traumatic avant, the Machinal Examinat runst be rediffied at 1 ☐ Yes 🂥 No Potomac Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8705 Wandering Trail Drive 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administrator Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Federline Martha Groth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Federline, Son 2315 Sandy Walk Way Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/06/05 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Gensee
Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland
299 Frederick Road Baltimore, once. Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 mas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (seem) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown Completed peen ; 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) nospice 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Diractor; After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding I within 24 hours after death.
To tha Funaral Diractor; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 455011 305 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien $^{2}05$ 28843 For State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2005° Month 08 **Physician** 25 Eleanor Farrar 11:15pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3561 Raymoor Rd. Kensington Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 79 Days 1 ☐ M 2 🖾 F 028-16-2009 **Director** 11-12-1925 Austria Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Itama 23s or 28e-f show the Medical Evernings must be rediffed at 1 ☐ Yes 2X No Director Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20895 3561 Raymoor Rd. USA death y Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene.

Hygiene.

other than "natural", or Ital 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Non-Profit permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hedy Latzko Ernst Schneider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6908 SW 37th Ave Portlan Orgon 97219 19a. Informant's Name/Relationship (Type, Print) Erin Farrar/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 08-27-2005 Beltsville MD 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave Silver Spring MD 20910 21. Signature of Funeral Service Licenses once. mo1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) I□Yes 2√2No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2x No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accide 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 2 08-26-2005 D40009 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persol Craig M. Person 7501 Greenway Dr. #220 Greenbelt MD 20770 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2005 0 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar 28844 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 2, Faith Elizabeth Franz 2005 12:40pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 5Ept. 2 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 □ M 2√2 F Director Maryland 55 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural", or Items 23e or 28e-f show eny injury or other traumetic event, the Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2☑ No Marvland Baltimore Parkville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3018 Acton Road 21234 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

le marked other then "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ben Franz 2 Paula Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ben Franz / Father 3018 Acton Road Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem↓ 9/6/05 Overlea, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease shock, or heart failure. toflions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death
Natural
2 \(\text{Accident} \) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

SEP 0 6 2005

30. Name and address of person who complet

egistrar's Signature

D08920

6569 N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 0 5

			1 - For State Registrar	State of Ma	aryiana / Dep <i>Ce</i>	ertificate of Deal	n and Mental H th	yglene 005	28845
	Physici	an	1. Decedent's Name (First, Middle, La	,			2. Date of D		3. Time of Death
	/Media		Victor	Joseph	Fleck	enstein	9	1 2003	
	Examir	er	4a. Facility Name (If not institution, giv	. 1	1	4b. City, Town, or Location	on of Death	4c. County of Death	
	Funeval		5. Social Security Number 6 6.5	-RE HOS	O I A I e (In yrs. last birthday	If Under 1 Year If Und	A C der 24 Hrs. 8. Date of B	BAITI	MORE
	Funeral Director		218-70-9640	M 2□F	48 Yrs.	Months Days Hour		3, 1957 Ma	nplace (State or Foreign untry) aryland
	yland		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Town or I	ocation			10d. Inside City Limits
	Ba-fst	Director	Maryland Baltimor	'e	Baltimo	re			1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number			10f. Zip Code		10g. Citizen of What Con	,
	ns 23	Funeral	7104 Oliver Beach	12. Was Decedent B	Ever in U.S. 13	21220 Was Decedent of Hispanic	Origin? (Specify Yes or N	U.S.A. No- 14. Race - Amer	
920	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or Items 23a or 28a-1 show event, the Medical Evartiner must be notified at	by	1 ☐ Never Married 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X] N If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mexical 1 ☐ Yes 2 🕅 No Specify Cuban, Mexical No Specific Yes 2 🕅		Specify:	
5-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occupation	unst of working	16b. Kind of Business/I	
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	e kind of work done during m DO NOT use retired)	iosi or working	Desirations	
1d 2	e filed within al Hygiene. cther than vent, the Ma	e e	17. Father's Name (First, Middle, Last)		Pilot	oengraver 18. Mo	ther's Name (First, Middl	Printing Je, Maiden Sumame)	
Maryland	should be nd Mental marked c	To B	Earl Joseph	Fleckenst	ein		Geraldine	Wdzieczkow	ıski
lan.	is a		19a. Informant's Name/Relationship (ing Address (Street and Num			
e,	1 and Health em 27 Ither tr		Vivian Fleckens 20a. Method of Disposition	<u>tein Wi</u>	fe 710	4 Oliver Beac	h Road Bal	Itimore Mary	
TOL	ages ant of it: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State		osition (Name of ematory or other place)		20c. Location - City or T	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	i	21. Signature of Financial Service Licer		2	Service Corp. 2. Name and Address of Fac	cility Ruck Tows	<u>Towson</u> son Funeral H	Maryland ome, Inc.
	40 F e 9		23a. Part1. Enter the disease, or com	cations that caused		1050 York Roa	d Towson,	Maryland 21	204 Approximate
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	e.	nor the mode of dying, such	as cardiac or respiratory	arrest,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	-15-50g			
	Examine:	- G	Sequentially list conditions,	b. Dissem	INATED -	ENTRAVASCU	LAK COAGO	ulation	
V	outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Hemol	Share the	iemia			
ő,	e exec ian an urial-tr		resulting in death) Last	Due to (or as	consequence of):				
68760,	rificate be executed ng physician and as the burial-transit	dlca		d. Chi	lympi	ocylic L	eu Kemia		
Box 6	es ig	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of				23d. Date of deliv	en
P.O. B	The law requires that the death cer ite has been signed by the attendir cage 2 should be detached for use	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth : 4 ☐ Pregnant at t 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		Month	Day Year
	res that igned b be deta	by PI	Part II. Other significant conditions c	ontributing to death bu	t not resulting in the	underlying cause given in Par	11. 23e. Did	tobacco use contribute to t	he cause of death?
ord	w require been sig should b						1 🗆	Yes 2 □ No 3 □ Proi	pably 4 Unknown
3ec	e law i has be	Completed					24a. Was	opsy prior to co	opsy findings available impletion of cause of
a	ician: Th certificate rector, pag		05 14(22 222 24(222 44 24 24 24 24 24 24 24 24 24 24 24				1 Tes		2 No
5	/sicia s certi directo	o Be	25. Was case referred to medical examiner?	Hospital: 1 Anpatier	nt 2 ☐ ER/Outpatie	Other	ce of Death Check only	one) sidence 6 □Other (Specia	
lo u	Attending Physician: r death. ector: After this certifice by the funeral director,	n: T	27. Manner of Death	28a. Date of Injun (Month, Day	/ 28b. Time o			how injury occurred	у)
S	tendir eath. tor: Al	catlc	17 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		,,	M 1 ☐ Yes 2 [□No		
Division of Vital Records,	ospital or Attendours after death nours after death uneral Director: ly filled in by the	Certification;	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		(Street and Number or Rura own, State)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Phi	ysician: To the best of iner: On the basis of and manner stat	examination and/or ir	h occurred at the time, date a vestigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner as s , date and place, and due to	tated. o the cause(s)
	To t withi To tl	Ž	29b. Signature and title of certifier	11/-		29c. License number		29d. Date signed (Month,	Day, Year)
			J. Bro Huchh	ath DO		RES OC	000	9/1/05	
	i5		30. ar e and a dress of person who d	completed cause of de	ath (Item 23a) (Type,	Print)	A. Q.IT.		
	Sta	e	DR Juseph Herche 31. Date filed (Month, Day, Year)	32. Pegistrai	r's Signature	RES OC Print) Klin Square	UR. BAILIN	HERE Md	11237
B	Registra		SEP 0 6 20	105	w St. Kg	and a			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#30, perpyr, C847, 9,6/05 TT

State of Maryland, Department of Health and Mental Hygiene 2006 1 - For Stata Registra 28846 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM FEINGOLD SEPT. 2005 6:04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 6. Sex 1 M M 2 □ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/30/1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 119-10-3858 85 N.Y. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY 1 ☐ Yes 2 No BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5225 POOKS HILL ROAD #1321N 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE 1 X Never Married 2 ☐ Married 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVID FEINGOLD **GELB** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELISSA HELLMAN/NIECE 2440 SYLVALE ROAD-BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 09/04/2005 RANDALLSTOWN, MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Fyral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a, Part1, Enter the di Approximate Interval Between Onset and Death or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. shock, or heart failu Immediate Cause (Final disease or condition resulting in death) MO Cancer ade nocarcinsmo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Dav 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

3,200

Physician /Medical Examiner 6.040.00 2005 The law requires that the death certificate be executed Box 68760, P.O. S. S. Records, Vital ō Division death. the within 24 hours after de To the Funeral Directo complete y filled in by th To the Hospital *30

DIT AN

EINGOLD

Completed by Physician/Medical

Be

29a. Certifier

29b. Signature

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be

Funeral

Director

r than "natural", or Items 23a or 28a-f ehow the Madical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any njury or other traumatic event, the Mades 2006.

Baltimore, Maryland 21215-0036

Medical Certification; To

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suburban Hospital, Bethesda, MD

Gabriel Peter Pushkas, 31. Date filed (Month, Day, Year)

SEP 0 6 2005



State of Maryland / Department of Health and Mental Hygiene 05

Cortificate of Death 28847 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ROY IVAN GRIM August 27, 2005 6:15 pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adeventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Days Months Hours 003-20-8755 76 Director May 19, Indiana Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ltems 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No XX **Funeral Director** MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 12811 Bluhill Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentai Hygiene. Int: If item 27 is marked other than "natural", or Itei MXYes 2□No 1953 If Yes, Give Year or Dates: -1956 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XTNO Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced -1956Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Language Analyst NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gaylord B. Grim ပ Clara Ohneck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu once. Dale E. Grim brother 33726 North Mill Road WIldwood, Illinois 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Kurial 2 Cremation 3 Removal from State Columbia Memorial Pki 9/2/2005 * 4 □ Donation 5 □ Other (Specify) Clarksville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 M00770 te, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician distosa avoude resulting in death) /Medical Due to (or as a consequence of): Examiner alete Sequentially list conditions, it among the conditions of the cause. Enter Underlying Cause (Disease or injury Physiclan/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the pasi 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Dther (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed this certificate 2 No 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

Director: Aff 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Modical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Dey, Year) 8-27-2005 45 203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue STEPHEN 32. Begistrar's Signature Takoma Park, MD 31. Date filed (Month) State 6 2005 Elisa. Registrar

Hward Grass

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 28848 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 645 AM WARD (PROSS 2005 /Medical 4a Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

Nar | If Under 24 Hrs. Decours 1405 pital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1**⊠**M 2□ F 218-10-6575 Director Yrs. APRIL 20, 1920 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Enacticer must be octified at Directo MARYLAND BALTIMORE 1 ¥Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ POPLAR U.S.FI or Items 23e 740 GROVE STREET 212110 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 \(\subseteq \text{No If Yes, Give Feb. 12, 1942} \) Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, any injury or other traumatic and the state of the s 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECURITY 8TH GRADE WATKINS SECURITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK GROSS ELIZA GROSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSS (CRAND DAUGHTER) 526 YALE AVE., BALTIMORE, MARYLAND 21229 PAMELA 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE CEM. 09-06-2005 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2140 No Fulton Avenue MD 2/2/1 Brown Daltimor Joseph H. Vr. Funeral. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclenti oronary Hurs /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit philipideina ECITS Due to (or as a consequence of): Box 68760 physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2X No Division of Vital 1 Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Dinpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 WNatural 2 Accident Injury 5 Pending death. s after death. 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after
To the Funerel Dir 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name a address of person FLEDERICK B. KOTZ 31. Date filed (Month, Day, Year) North Greene 32. Tugistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18,20a,22, perFH C847, 9/6/05 TT

State of Maryland Department of Health and Mental Hygiene 2000 28849 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Judy Heinlein /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 820 West Bel Air Avenue #236 Harford Aberdeen | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 12, 1946 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√2F Washington DC 59 Yrs. Director 219-48-9189 Usual Residence of Decedent 10a State 10c. City. Town or Location 10b Counts 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at MD 1 ☐ Yes 2 ☑ No Harford Director Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 820 West Bel Air Avenue #236 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker own home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 2 should be f and Mental t Delbert Heinlein 2 Anna C. Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 820 West Bel Air Road #236 Aberdeen, MD Anthony Giordani/spouse 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' permit. Pages Department of Important: If it any injury or o 09/02/05 Baltimore, Maryland `4 □Donation 5 ♥Other (Specify) in state Metro Crematory Inc. 21. Signature of Juneral Service Licensee Ronald Wa 22. Name and Address of Facility Crematory Society of Maryland 21201 Baltimore, MD 21201 21228

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for an a consequence of Examiner certificate be executed Due to (or as a consequence of): burial-1 physician Box 68760 Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 WUnknown been signed be should be detailed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a Wasan autopsy performed? 1 Yes 2 No of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1-☑ Yes 2 2 🗌 No this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide To the Hospital within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of page 1 completed cause of death (Item 23a) (Tyge, Print) DME 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

HEINLEIN

			1 - State Amend Item 1 Registrar		347 9-6- J. Harma		cate of De			-3	105	28850		
	Physici	an	1. Decedent's Name (First, Middle, L		2. Date of Dea Month Septemb	Day	Year 05	3. Time of Death						
	/Medic Examin		David J. II 4a. Facility Name (If not institution, g.	cation of Death	beptellib	4c. County		1:06 p м						
	Exami	lei	Gilchrist Center for Hospice Care Towson Baltimore											
	Funeral			Sex 7. Age	e (In yrs. last bir	rthday) If	Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day JUL 25			ace (State or Foreign try)		
*	Director		212-38-0976	1 ⊠ M 2□F	67	Yrs.	Jay 5		JUL 25'	1938		MD		
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	n				10	Od. Inside City Limits		
	Mary -I sho	ō	NJ Union		Scoto	h Pla	ins					1 ☐ Yes 2 No		
	ith the Marylar or 28a-f show e notilled at	lrec	10e. Street and Number		5556		Of. Zip Code		1	Og. Citizen of	What Coun	try?		
	ath with the Maryla s 23a or 28a-f show	Funeral Director	2669 Fairview Dr	ive			07076			USA				
	r dea	Juer	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was	Decedent of Hispai s, specify Cuban, M	nic Origin? (Spec fexican, Puerto R	ify Yes or No- lican, etc.)		e - America ck, White, e			
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-1 show ant, the Medical Examili of must be notified at	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	10	res 2X No Si	pecify:		Specif	whi	te		
Maryland 21215-0036	72 hours 'natural' dical Ex	ted	15. Decedent's	Education	16a.	. Decedent'	s Usual Occupation	1 .		16b. Kind of B				
215	thin 7.	Be Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	+)	(Give kind life. DO N	of work done durin IOT use retired)	ng most of working		Metal 1				
21	be filed withintal Hygiene. Ind other than avant, ir.	Соп	12		Ow	mer/M	lanufactu			Manufa		ng		
pu	9 m 2 3	Be	17. Father's Name (First, Middle, Last Carroll Nevi	Harman				Mother's Name (Frankie	(First, Middle, 1 E li za		™ Whea	+1017		
<u>₹</u>	2 should be for and Mental His marked of raumatic avairance.	2	19a. Informan's Name/Relationship		106	Mailing A	idress (Street and							
	es 1 and 2 should b of Health and Ment f item 27 is marked r other traumatic a		Harman Anna Harman - wi	_		_	irview D					7076		
Co Co timore,	Pages 1 a nent of Hei int: if item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	□Removal Irom State	20b. Place of cemeter	l Disposition ry, cremato	(Name of ry or other place)	Da	ite	20c. Location	City or Tov	wn, State		
tin Social	t. Pag rtment rtant:		4 □Donation 5 □Other (Spec	rify)	Chesape		enatory Inc		005	Beltsv	ille,	MD		
Ba	permit. Pages Depertment of I Important: if ite any injury or or		21. Signature of Funeral Service Lio	ensee	M00986	CAF	Me and Address of A, Stephe 7 Green I	en D. Lo	rhmann,	PA	a MD	21286		
30	* * *	Г	23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that caused	the death. Do	not enter th	e mode of dying, su	uch as cardiac or	respiratory arr	est,	1, 1910	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition		/	bat-	c Lun	a Car	ICER			Onset and Death		
	/Medical		resulting in death)	Due to (or as	a consequence	ol):	C 4071	7				Jean		
	Examiner	<u>.</u>	Sequentially list conditions,	b										
.7	ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):								
ts -	xecut and al-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence	of):		<u> </u>						
0/2	rtificate be executed ng physicien and nas the burial-transit	cal		d										
75 X	E 0 6	Ved	IF FEMALE:											
Box	eath cer attendin for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death	3 □Ecto	ppic pregnancy				te of deliver	ry Day Year		
~ 0	The law requires that the death ce are has been signed by the attendi page 2 should be detached for use	Physician/Medical	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 🗌 Oth	er (specify)			1410		Day real		
avica ds, P.C	that lhe de led by the detached	y Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in	n the under	ying cause given in	Part I.	23e. Did tol	pacco use cont	ribute to the	e cause of death?		
S p	quires n sign ald be	d by					_		XY	es 2□No	3 🗆 Proba	ably 4 □Unknown		
O C	law requir as been s 2 should	plete							24a. Was a	n 24b.	Were autop	sy lindings available		
<u> </u>	The late has page	Completed							autops perform	ned?	orior to com death? I □ Yes :	npletion of cause of		
Vital	iclan: certifice ector, p	Be	25. Was case referred to medical examiner?					. Place of Death	(Check only on	e)				
of V	Physician: r this certificated in all director, in	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie			DOA Other: 4	4 ☐ Nursing Hom			er (Specify	Hospice		
	ding Physician: After this certific funeral director,	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	Year) 28b.	Time of Injury	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	3d. Describe ho	ow injury occur	red	,		
farm	P C S	ficat	2 Accident investigati 3 Suicide 6 Could not determine	be con Diagonal Initia	urv - At home, la			2 🗆 140	31. Location (St	reet and Numb	er or Rural	Route Number.		
700	s after de safter de la Diract	Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)	,	,		City or Town					
	To the Hospitel or Atti within 24 hours atter de To the Funeral Direct completely filled in by ti	Medical	(Check only 2 Medical Exa	Physician: To the best of aminer: On the basis of	examination an	e, death occ	urred at the time, d gation, in my opinio	date and place, an	nd due to the ca	ause(s) and ma ate and place,	inner as sta and due to	ated. the cause(s)		
	within 2 To the comple	Med	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
	F > F 0		> 91. Ant	hony Re	leg, c	us	025	205	S	epten	ber	1,2005		
	20		30. Name and address of person wh	o completed cause of de	. 1/2 30	(Type, Print	Charles S.	7 Rett	5 IM-1	7 / 3 /				
	Sta	ite	31. Date liled (Month, Day, Year)	32 Registra	ar's Signature	10-0	surces J.	1.1200	. ma	0120	<i>></i>			
	Regist		SEP 0 6 2	437.	1/8	Prince	20							

28851

1	-	For Stete Registrer
-		negistrer

6:30 а.ш.

SEPTEMBER 2, 2005

FRANCIS HURLEY

	1 - Stete Registrer Ce	rtificate of Death	Reg. No.
* * * * *	Decedent's Name (First, Middle, Last)		of Death 3. Time of Death
Physician /Medical	Francis Xavier Hurley	Sep.	tember 2 2005 6:30 a M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Stella Maris Dulaney Valley	Timonium	Baltimore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. (Months)	of Birth th. Day. Year) 9. Birthplace (State or Foreign Country)
Director	215-18-3031 1 [™] 2□ F 83 Yrs.	MAR	22 1922 MD
pu v	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	and tion	10d. Inside City Limits
sho sho			1 ⊠ Yes 2 □ No
t 28a-f show	MD N/A Baltimore		
Mith to be or	221 Stony Run Lane	10f. Zip Code 21210	10g. Citizen of What Country? USA
Site death with the Maryland friteme 23e or 28e-f show piner must be notified at Funeral Director			
5 2 E E	1 Never Married 2 Married 1 Never Married 2 No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	Black, White, etc.
5-0036 72 hours after neturel; or ite	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2X No Specify:	Specify: white
21215-00; ed within 72 hours ygiene. ner then "neturel" it, the Medical Ex	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
within 7 see. then 'n te Med	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	
d 212 filed within Hygiene. then then then out, tre Mi	5+ Attor	ney	State of Maryland
be filed the dother ovent,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, A	AND STREET STREET
should be in a Mental in marked o umatic eve	John Hurley	Catherine	Moran
ds and and		ng Address (Street and Number or Rural Route Stony Run Lane, Baltin	
Ore Des 1 Tof H or oth	20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State	matory or other place)	20c. Location · City or Town, State
timen tant:		Crematory Inc 9/3/200	
Baltimore, permit. Pages 1 at Deperment of Hea Important: If term eny injury or othe	21. Signature of Funeral Service License	AFA, Stephen B. Lohrma	ann, PA
40200	1100900	3717 Green Pastures Dr	ive, Towson, MD 21286
	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ler the mode of dying, such as cardiac or respira	tory arrest, Approximate Interval Between Onset and Death
Physician -	Immediate Cause (Final disease or condition resulting in death)		
/Medical Examiner	Due to (or as a consequence of):		
W. W.	Sequentially list conditions, if any, leading to immediate b		
In sit	cause. Enter Underlying Cause (Disease or injury		
executed executed rial-transit	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
S 8 3 3 5	d ====================================		
certificate be executed digraphysicien and use as the burial-transit			
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	75	23d. Date of delivery
death death de atten	in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)	Month Day Year
, P.O. Bc that the death the by the atter detached for u	9 Unknown		
S, I es the igned be de	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e	. Did tobacco use contribute to the cause of death?
ecords, law requires as been sign 2 should be			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
Receipment of the second of th		24a	. Was an autopsy findings available prior to completion of cause of
II Record The law requir cete hes been s page 2 should		10	performed? death? Yes 2 No 1 Yes 2 No
Vital	25. Was case referred to medical examiner?	26. Place of Death Check	
Of Vita Physician: this certific ral director. To Be (1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		Residence 6X1Other (Specify) HOSPICE
ion canding Path. r: After le funera	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	cribe how injury occurred
ISIC Itend Heath Iter	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	
Division of Vital Records, tel or Attending Physician: The law requires the state death. The law flower and the this cardificate has been signed in by the funeral director. Page 2 should be constituted by the funeral director. Page 2 should be constituted by the funeral director.	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	ition (Street and Number or Rural Route Number, or Town, State)
Hospitel Hospitel Funeral tely filled	29a. Certifier 1X Certifying Physician: To the best of my knowledge, deal	h occurred at the time, date and place, and due	to the equation and
Division To the Hospitel or Attenwithin 24 hours after deall within 24 hours after deall completely filled in by the Medical Certifical	(Check only one) Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		1)42725	9/2/05
111	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	11-700
14	DR. TARIQ MAHMOOD 2300 DULANEY VAL		21093
State	31. Date filed (Month, Day, Year) 32. Agigistrar's Signature	Carli	
Registrar	SEP 0 6 2005 Status & A		

State of Maryland / Department of Health and Mental Hygiene 2005

				1 - State Registrar			•	<i>(</i>	Certi	ificate of	Death	7		Reg. No	2003) (883) [
				1. Decedent's Name	e (First, Middle, L	ast)		2						2. Date of Death 3. Time of Month Day Year				n
		Physicia /Medic		June Yvon					Septem		1, 200	5 143	0	М				
		Examin		4a. Facility Name (I	-				4b. City, Town, or Location of Death					4c	. County of Dea	th		
				Upper Che	-						Bel A				rford			
		Funeral		5. Social Security N		Sex 1 □ M 2 F	7. Age (1	In yrs. last birth		If Under 1 Year Months Days	Hours	Min,	8. Date of Bi (Month, D	irth ay, Year)	9. Bir	thplace (Sta ountry)	ate or Fore	sign
		Director		218-26-41 Usual Residence of		1			J.		<u> </u>		06/28/	1930	MD			
		ow at		10a. State	10b. County	<u></u>	1	0c. City, Town	or Loca	tion						10d. Insid	e City Lim	iits
		the Marylan 28a-f show	tor	MD	Harford		.	Joppa								1 🗆	Yes 2	Mo
		h the	Director	10e. Street and Nur	mber					10f. Zip Code				10g. Cit	tizen of What C	ountry?		
		death with the Maryland ms 23s or 28s-f show		1010 Јорр	a Road					21085				Unit	ed Stat	.es		
		r dea	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Eve rces?	er in U.S.	13. Wa	s Decedent of I	Hispanic O an, Mexica	rigin? (Spe an, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whi		n,	
	36	s afte	by Fu	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married	If Yes, Giv	/0			Yes 2					Specify. Whi			
	21215-0036	hour tural		3 🗆 ***********************************	15. Decedent's E	Year or D	ates:	169 [)eceder	nt's Usual Occup	nation			16h K	(ind of Business			
	15	n "ne	Completed	(Spec	ify only highest g	rade completed)	1 4005.)		Give kii life. DC	nd of work done NOT use retire	during mo	st of worki	ng		Lth Care			
3	212	d with	mo	12	indary (0-12)	College (1	1-401 5+)	Reg.	istı	car								
0		al Hy l othe vent,	Be C	17. Father's Name		st)					18. Moth	ner's Name	(First, Middle	e, Maiden	Sumame)			
7	Na N	Ments Ments arked	To	Walter C.	. Jones						Alve	rdia <i>l</i>	A. Crum	rine				
1	Maryland	and and is my		19a. Informant's Na				1							or Town, State,	Zip Code)		
1/05		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, Ite Medical Examinations to institute a some.		Harold Huj		/husband		20b. Place of D		oppa Ro	ad Jo					T 0:		
-	altimore,	iges in of h			Cremation 3		State	cemetery,	crema	tory`or other pla	1	S	ep_3		ocation - City or			
2	ij	it. Pa rtmer rtant njury		' 4 □ Donation 21. Signature of Fu	5 Other (Spec	•		Chesape		Cremat			005		sville,	Maryıa	ana	
	Ba	permi Depar Impo any Ir		21. Signature of Fu) C	D ir	MA	111112	Cre	Name and Addre mation a	nd Fu	neral	Altern	ative	es			
				23a. Part1. Enter the	he disease, or cor	mplications that of	aused th	e death. Do no						_	nore, Man	Approx	mate	
		Di		shock, or hea	rt failure. List on! (Final	y one cause on e	ach line.	1/				1				Interval	Between and Death	٠
)	Physician / /Medical		disease or condition resulting in death)	in 🗾	a. Due to	Orasao	consequence of		dial	INT	arco	1(01)			IW	æk	•
		Examiner		Maria Company of the			(0. 00 0		,									
	ш		ner	Sequentially list coin any, leading to imcause. Enter Under	nditions, nmediate	Due to	(or as a c	consequence of):									
5	V	he death certificate be executed the attending physician and hed for use as the buriat-transit	Examiner	that initiated events	injury	C												
-	30,	e exe sian a urial-		resulting in death) I	Last	Due to	(orasa.c	consequence of):									
1300	68760,	cate b	Medical			d												
Ö	9 ×	ding page as	/Me	IF FEMALE:		23c. If yes, out	come of	D/DGD3DGV										
A	Box	death c	ian	23b. Was decedent in the past 12	months?	1∐Live b	irth 2 [Fetal death		ctopic pregnanc	у				23d. Date of de Month	ivery Day	Year	
	o.	es that the death cer igned by the attendir be detached for use	Physician	1 ☐ Yes 2 9 ☐ Unknown		9□ Unkn		ne or deam	200	nner (specify) _								
7	<u>α</u>	ires that the signed by		Part II. Other signif	ficant conditions	contributing to de	eath but r	not resulting in t	he und	ertying cause gr	ven in Part	l.	23e. Did	tobacco i	use contribute to	the cause	of death?	
5	ecords,		d by	Cevebr	al vascu	ilar di	seas	se H	100	v tens co.	n	9001	10	Yes 2	⊅ (vo 3□Pr	obably 4	Unkno	₩n
3	00	3 0 70	olete) /	, ,		1 4	9	24a. Was	s an	24b. Were at			
-	$\mathbf{\alpha}$	The law ate has by page 2 st	Completed										auto	ormed?	death?	completion 2 No	of cause o	əf
2	Vital	iiclan: Th certificate rector, pag	a	25. Was case refer	red to medical						26. Plac	e of Death	1 ☐ Yes	20 No one)	1 105	2 140		
F	1	Physician: this certific	To B	examiner?	No	Hospital: 1 🔲 I	npatient	2 PVOutp	atient	3□ DOA Ott	ner: 4 🗆 N	lursing Hon	ne 5□Res	idence	6 ☐Other (Spe	cify)		
, 2	n of	ng Pl		27. Manner of Deat	5 ☐ Pending	28a. Date (Mon	of Injury th, Day Y	'ear) 2 b. Tir		28c. Inju	ry at rk?	2	8d. Describe	how inju	ry occurred			
g	Sio	eath. or: A	catle	2 Accident	investigati						Yes 2]No						
uppen	Division	or Ati	Certification;	3 ☐ Suicide 4 ☐ Homicide	determine	d 286. Place	of Injury ng, etc. (- At home, farn (Specify)	n, stree	t, factory, office		2	8f. Location (City or To	(Street an wn, State	nd Number or Ri e)	iral Route l	Vumber,	
+		pital ours a eral [29a. Certifier	Cartifying 5	hyeician, To the	hast of a	mu knowledge	danth a			-4-1			\			
		To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one)	2 ☐ Medical Exa	Physician: To the aminer: On the band man	asis of ex	camination and/	or inves	stigation, in my	opinion, de	ath occurre	d at the time,	, date and	d place, and due	to the cau	se(s)	
_		To th within To the	Me	29b. Signature and	title of certifier		`	/		29c. Licens	se number			29d. Dai	te signed (Mont	-	.'	_
)			1	MANY	ANO	mv	V		H	1410	069		Sel	Plember	12,	2009	2
		10		30. Name and addr			_	/ 1		AR E	1. 1	Т	1	1	M . A		_	
				MK-STW			308		155	(enter	100	y t	agea	bod	141)	2104	U	
		Sta Re gistr		31. Date filed (Mon	Ab est -	2005	gistrars	Signature	1	anti B		,						
					ULI U U	-000 J	A AR	15	100									

Amend 1tem Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 055 28853 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year SANDRA L. HUNTER 08.26. 10:00 AM 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TOWSON GILCHRIST NURSING CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O3 . O1 . D46 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🗷 F 59 215.44.6199 Yrs MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No NIA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SHIELDS PLACE 1134 USA 21201 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE 121H GRADE HOSPITAL NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES WEAL. ORELLA WHITE 19a. Informant's Name/Relationship (Type, Phus band 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDER HUNTER HUNT BALTO. MD 21201 1134 SHIELDS PLACE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT 09.03.05 BALTIMORE 21. Signal re of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. MATU PIKE, BALTO. MD 21229 ansh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -AnceR disease or condition resulting in death) N ears) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Qualto (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Department of himportant: if ite any injury or of once.

Physician

/Medical

Examiner

Funeral

Director

show

28a-f :

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items 23a

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"natural",

is marked other than

item 27 i

traumatic event, the Medical

nust be notified at

Directo

Funerai

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Completed

Be

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit The law requires that the death certificate be executed ed by the a detached f been signed by should be detacl cete has t page 2 s certificete or Attending Physician: this After thi within 24 hours atter useur.

To the Funeral Director: Af

Division of Vital Records, P.O. Box 68760,

Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Was an autopsy performed? 1 ☐ Yes Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 XNo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide

1 ☐ Yes 2 ☐ No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 ther (Specify) 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier 29c. License number

St. Balts. Ad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12: 6701

State Registrar

Medical

31. Date filed (Month, Day, Year)

6 2005

32. Registrar's Signature

TOUIS EDWARD ROLMES SOUTH SECURITY PROJECT TO		1 - For State Registrar	State of Marylar	Cer	tificate of L	Death	nentai my	gleri 2 005	28854
46. Posity Name of Productions by Secretary Observations (Control of Secretary Observations) (Control	hysician /Medical					S	Month		3. Time of Death 5 4: 05 A
218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 218-03-709 South 219-03-709 South 229-03-709 S	xaminer			er	4b. City, Town, or			4c. County of De	ath
Description of the Control Description of	neral ector		19€ M 2 □ F	-			8. Date of Bird (Month, Da	th 9. B y, Year) 9. B	inthplace (State or Foreig Country) ARYLAND
150 Decederate Situation (Speech) 150 Nind of Business/industry 150 Nind of Business/ind	=	Usual Residence of Decedent	10c. Ci	ty, Town or Loc	ation				10d. Inside City Limit
Special companies Special companies Special companies Special continues Spec	ctor	MD			BALTIMO	RE			Y☐Yes 2☐No
150. Decedent Schulation 150. Decedent Schulation 150. Maintenance 150. Maintenan	Dire								Country?
Second control Seco	era		· · · · · · · · · · · · · · · · · · ·	IS 13 W		spanic Origin? (Sr	necify Yes or No		perican Indian
Specified Secretary Secretary (0-12) Specified Secretary Secretary (0-12) Specified Secretary Secretary (0-12) Specified Sec	by Fun	1 Never Married 2 Married	Armed Forces?	-1945 ¹			Rican, etc.)	Specify	tite, etc.
18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maskins Summane)	eted	15. Decedent's 1	Education rade completed)	16a. Deced	ent's Usual Occupa	ation during most of work	una	16b. Kind of Busines	s/Industry
18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maskins Summane)	Comple	Elementary/Secondary (0-12)	College (1-4or 5+)	1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9	Domestic	
239 Titl. Enter the disease, or confusions that caused the death. Do not enter the mode of dying, such as cardact or respiratory arrest. Approximate finewal Baw Ones and Title Card on each line. Approximate finewal	Be	17. Father's Name (First, Middle, Las	(t)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
The state of the s	P P		(Tuna Brint)	10h Mailin				- O' T	7:- 011
Table W. North Ave. Batto., Md 21217 Table State of Death Cause of the death. Do not enter the mode of dyng, such as cardad or respiratory arrest. Approximate interval Baw Ones and June 1 to the final resulting in death) The death of th			•						Zip Code)
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The state of the s			THO						
232 mill Einer the disease, or coordinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate Cause (Final disease, or coordinations to cause on each interval Bate (Chest of the Cause (Final disease) or conditions. Sequentially list conditions. Seque	once	21. Signatury of 1 unional convice Electrical							P.A.
A DENO CARCINOMA OF LUNG Sequentially ist conditions, and and its constraint of the control o		23 Part 1. Enter the disease, or co	lications that caused the dear						Approximate
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Sequentially list conditions, its adding to immediate gause. Enter Underlying cause. Enter Underlying. Enter Underlying cause. Enter Underlying. Enter Under	cal	resulting in death)	F W		OI LUIN	<u></u>			
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of the part of		Sequentially list conditions,	b		TIVE PU	LMONARY	DISEA	SE	
Due to (or as a consequence of): Due to (or as a consequence of):	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
FEMALE: 23b Was decedent pregnant in the past 12 months? 1	al Exan	that initiated events	Due to (or as a consec	quence of):					
25. Was case referred to medical examiner? 1 Yes 25 No 24b. Were autopsy findings an autopsy performed? 1 Yes 25 No 25 No 25 No 25 No 25 No 26 Place of Death Check only one) 26. Place of Death Check only one) 27. Manner of Death 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident 1 Yes 2 No 28c. Injury at	<u>a</u>	IF FEMALE:	d						
24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death Check only one 27. Manner of Death 1 Month, Day Year 28b. Time of Injury 28a. Date of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Numb building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day). Year)	ysician	in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c	al death 3					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204	by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause give	en in Part I.			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER F. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204	eted						-	-	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER F. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204	Compl						autop	osy prior to rmed? death?	completion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER F. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204	necto	examiner?	Hospital:	Teno	-C - Othe				
JOGINDER F. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204	funeral d	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at			ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA. M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204	d in by th		d 286. Place of injury - At n	nome, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER F. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204	edical C	Check only 2 Medical Ext	aminer: On the basis of examina	owledge, death ation and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner added	as stated. ue to the cause(s)
JOGINDER P. MEHTA. M. D. 7601 OSLER DRIVE. TOWSON, MARYLAND 21204	W		mella	m.0			Ç	29d. Date signed (Mor	nth, Pay, Year)
Os Date Clad (March Day Very)	7	30. Name and address of person wh	completed cause of death (Item	m 23a) (Type, F					
Os Date Clad (March Day Very)	,				ER DRI	VE. TOW	SON. M	ARYLAND 2	21204
	State legistrar	31. Date filed (Month, Day, Year) SEP 0 6-2	32 registrar's Sign.						

Charles Harrison 05-05964 NJM

_	•		1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment rtificate	t of H	ealth a Death	and M	lental Hy	giene Reg. No.	005	28855	
	Physic		Decedent's Name (First, Middle, La: CHARLES	st)	Н	ARRIS	ON			2. Date of De Month	Day	Year	3. Time of Death	
	/Medi Examii		4a. Facility Name (If not institution, give	e street and number)				Location o	f Death	TOPPOPULE E DOOP			0110	
			Sinai Hospital				timo				N/A			
	Funeral		5. Social Security Number 6. S	ex 7. Age (I	n yrs. last birthday)	If Under Months	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth	8. Date of Birth 9. Birthplace (SMOnth Cay, Year) 9. Country)				
	Director		213-10-7847 Usual Residence of Decedent	X	86 Yrs.				-	MAR.23	,1919		ΜD	
	nylanc how		10a. State 10b. County	10	Oc. City, Town or Lo						10d. Inside City Limits			
	the Marylar 28a-f show	ctor	MD BAL	TIMORE	BALT	IMORE							1 ☐ Yes 2 🕅 No	
	vith th	Dire	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Co	•	
	eeth w	era	7 LEAFYDALE COU	R I 12. Was Decedent Eve	er in U.S. 13.	21208					144	D 4	USA	
(0	72 hours after deeth with the Maryland nature!', or iteme 23a or 28a-f show iteal Exam or must be confilled at	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 (X) Yes 2 □ No If Yes, Give		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14	Race - Ame Black, White	e, etc.	
93	ours aft rei', or Exem	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:			S	pecify:	WHITE	
21215-0036	72 hours "naturel", edical Exe	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece (Give	dent's Usua kind of won DO NOT us	l Occupa k done di	tion uring most	of worki	ng	16b. Kind	of Business/	Industry	
121	withir ene. then the M	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ECTOR	e retired)				RΔIT	IMORE	CITV	
	Hygi other	Be Co	17. Father's Name (First, Middle, Last)		11(3)	LOTOK		18. Mothe	r's Name	(First, Middle,			CITT	
Maryland	ges 1 and 2 should be filed within 72 hours after deeth with the Maryla It of Heelth and Mental Hygiene. If item 27 is marked other then "nature!", or iteme 23a or 28a-f show or other treumatic event, the Madical Exam are must be contined at	To B	HARRY		HARR	ISON		JEN	NIE			,	MOSKOWITZ	
lan	and h		19a. Informant's Name/Relationship (7	Type, Print)						l Route Numbe			Zip Code)	
	l and teelth im 27 her tr		EVELYN HARRISON						-	ALTIMORI				
סר	or of		20a. Method of Disposition 1	I TOTTIO TALLIO III GILLIO		sposition (Name of Date 20c. Location - City or Town, State crematory or other place)								
Baltimore,	permit. Pages 1 and: Department of Heelth Important: If Item 27 any injury or other tr <u>once</u> .		4 Donation 5 Other (Specify) CHIZUK AMUNO ARLINGTON 9/2/2005 BALTIMORE, MD 21. Signature of Funeral Sargin Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC.											
Ba	Departr Imports any inj		by Wey Weer		MD 21208									
			23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition Allows & Donotus Condition Disease or condition										Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):			- , - ,						
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of);									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,									
o,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):									
8760,	3 5 6	Physician/Medical	•	d										
9	leath certifica attending ph ifor use as th	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy									
Вох	death atten	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 □ 4 □ Pregnant at tim	Fetal death 3	Ectopic pre Other (spe					230	 Date of deliment Month 	very Day Year	
P.O.	t the de by the a	hys	9 Unknown	9□ Unknown										
	es tha igned be del	Бу Р	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the ur	nderlying ca	use giver	in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	
of Vital Records,	w requir been si should	te d								1 🗆 Y	es 2 🗆 N	No 3∏Pro	bably 4 Dunknown	
3ec	: The law cete has b , page 2 st	Completed								24a. Was a autop	sy	prior to c	topsy findings available ompletion of cause of	
a			OF Monocon referred to the first							perfor 1 X Yes	2 □ No	death?	2 🗆 No	
Ξ	Physician: ' this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 □ No	Hospital:	2 ☐ ER/Outpatien	t 3□ DOA	Other			Check only or				
Jo L	ding Phy h. After thi funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Ye		lc. Injury a Work?	4 LI raur		ne 5 Resid			ify)		
Si	endin eath. or: Af he fur	atlo	1 Natural 5 Pending 2 Accident investigation		s 2 🗆 N	o								
Division	spital or Attene ours efter deatl teral Director: filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory,	office		2	8f. Location (S City or Tow	treet and N n, State)	lumber or Rui	ral Route Number,	
	Hospital 24 hours e Funeral (29a. Certifier 1 ☐ Certifying Phy	(sician: To the best of m	ny kaoudadan daeth		A 4b - 4i	4-4						
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2X) Medical Exam	sician: To the best of mainer: On the basis of example and manner stated	amination and/or inv	estigation, i	n my opii	, date and nion, death	piace, a	nd due to the c id at the time, d	ause(s) and ate and pla	d manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the complet	ĕ	29b. Signature and title of certifier	011		29c.	License	number		2	9d. Date s	igned (Month	. Day, Year)	
,	4		MAN	5/1/			OCI	OCME September, 1, 2005				, 2005		
6	1		30. Name and address of person who c	completed cause of death	(Item 23a) (Type, I		l Por	n St	root	Ral+i	moro	Marzzl	and 21201	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature John		r rel	ш ЮС.	reer	Daill	more,	rar yı	and 21201	
	Registr		SEP 0 6 200	Despess.	200 Palace									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death

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	Funer Directe	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural, or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinat must be notified at	
	Physicia /Medica	

	-		1. Decedent's Name	e (First, Middle, La						2. Date of E	Death Day	Year	3. Time of Death	
	Physici /Medio				Richar	d Jones	es, Jr. Septemb							
	Examir		4a. Facility Name (I	f not institution, giv	re street and number)			4b. City, Town,	or Location of Death		4c. County of Death			
	-		805 Scot					Baltimor			N/A	A		
	Funeral Director		5. Social Security N 214-64-1	0715	Sex 7. Age 1024 M 2 □ F	(In yrs. last birth	day)_ rs.	If Under 1 Year Months Days			8, 1955	9. Birth	place (State or Foreign try) laryland	
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										IOd. Inside City Limits	
	Ba-f eh	ctor	Maryland	N	N/A			В	altimore				1 Yes 2 No	
	th with the	al Director	10e. Street and Nur 805 Scott S					10f. Zip Code	21230		10g. Citiz	zen of What Cour U.S.A		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other then "natural; or items 23a or 28a-f ehow imatic event, its Medical Exeminer must be notified at	y Funeral		ied 2□ Married	12. Was Decedent E Armed Forces? 1 Yes 2 X No If Yes, Give			as Decedent of Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify:		
ğ	urai',	d by	3 Widowed		Year or Dates:									
Ϋ́	n 72	ete	(Spec	15. Decedent's E lify only highest gra	ducation ade completed)	1 (Give k	ent's Usual Occu ind of work done O NOT use retire	during most of wor	king	16b. Kir	nd of Business/Inc		
71.	within 72 iene. then "na	Completed	Elementary/Seco	ndary (0-12)	College (1-4or 5+	+)	11 0 . D		akeman			Railroad		
and	d be filed antal Hygis ted other c event, ii	Be	17. Father's Name		Jones Sr.		18. Mother's Name (First, Middle, Maiden Surname) Shirley M. Jones							
Maryland 21215-0036	d 2 array	ဥ	19a. Informant's Na Samuel Jo		Type, Print)	19b. I			and Number or Ru et Baltimore,			Town, State, Zip	Code)	
Baltimore,	ages 1 and 3 ant of Heelth it: If Item 27 y or other tra				Removal from State	cemetery,	of Disposition (Name of tery, crematory or other place) r Hill Cemetery & Mausoleum 09/09/05 Brookl						own, State ark, Md.	
Baltir	permit. Pages 1 an Department of Heel Important: If item 2 eny injury or other 9058.		21. Signature of Fu		1	Cedair	-	Name and Addre		eral Service	, P.A.	247 Politima	vo Md	
	Physician /Medical Examiner		Immediate Cause (disease or condition resulting in death)	(Final n	b	SUS OY consequence of	2	the mode of dyi	ng, such as cardiac				Approximate Interval Between Onset and Death	
68760,	eath certificate be executed attending physicien and for use as the burial-transit	edical Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) L		с.	consequence of								
O. Box	the death certif y the attending sched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death		ctopic pregnanc Other (specify)	у		2:	3d. Date of delive Month	ory Day Year	
cords, P	w requires thet the d been signed by the should be detached	ρ	Part II. Other signifi	icant conditions o	contributing to death but	not resulting in t	he und	lerlying cause giv	ven in Part I.		tobacco us	,	e cause of death?	
e T	hes hes	Completed								24a. Was		prior to con death?	osy findings avaitable inpletion of cause of	
VItal	ician: Th certificete rector, pag	Be	25. Was case referr	red to medical					26. Place of Dear			, 2 103		
> 0	\$.2. ₹	ည	1 ¥ Yes 2□	No	Hospital: 1 Inpatient	t 2 ER/Outp	atient	3□ DOA O#	ner: 4 Nursing Ho	ome 5 ☐ Res	idence 6	ther (Specify	Scene	
	ding h. After	atlon:	27. Manner of Death 1 SNatural 2 ☐ Accident	5 Pending investigation			ne of ury	28c. Injui Wor M 1	yat rk? Yes 2 ⊡ No	28d. Describe	how injury	occurred		
=	3 ± = c	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		y - At home, farm (Specify)	, stree	et, factory, office		28f. Location City or To	(Street and wn, State)	Number or Rura	l Route Number,	
	FE T	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.									and manner as sta place, and due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and	title of certifier	re Ukrell m	W.		29c. Licens				signed (Month, L		
6	7	ŀ	30. Name and addre	ess of person who	completed cause of dea	ath (Item 23a) (Ty	/pe, Pi		л. Б.		pehre	mber 03,	2005	

State Registrar MARYDRITS

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygien 2005

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-	$\mathbf{\mathbf{\mathcal{C}}}$	V	V	

Physician Augusta County Augusta County of Death			= State Registrar				Cer	tificate of	Death		Reg. No.	, , ,	2000
## Fellow Jundkins Application of Death Section	*	4	1. Decedent's Name	(First, Midd	lle, Last)								3. Time of Dea
## Facility Name in Principles Control and number) ## Facility Name in Principles ## Facilit	4.5				L	lolon lu	dkin			Month			40.45
Control Control Cont		_	4- 5-38-11				UKIII						12:15 a
\$ 300 and absorbing number 0.5 per 1.0 per	Examine	er	4a. Facility Name (if i	not institutio	on, give street and num	ber)		46. City, 1 <i>o</i> wn,	or Location of Di	eath	4c. Cot	inty of Death	
10 10 10 10 10 10 10 10		8			Gilchrist C	enter				Towson		Balti	imore
Part Part	Funeral		5. Social Security Nur	mber	6. Sex 7	. Age (In yrs. last	birthday)				rth	9. Birthr	place (State or Fo
Use Residence of Decelorary 100 Design of Decelorary 100 D	Director		237-22-1	3089	1 □ M 2 💢 F	97	Yrs.	Months Days	S Hours N			Cour	
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25. Was case referred to medical examiner? 1	S S S	D D	ren	al	tailu	re				1 🗆	Yes 2 No	3 ☐ Prob	ably 4 DUnk
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29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) August 26, 20 30. Name any addry of person who completed cause of death, i.e. 23a) (Type, Print) August 27 26, 20 29c. License number 29d. Date signed (Month, Day, Year) August 26, 20 30. Name any addry of person who completed cause of death, i.e. 23a) (Type, Print) Chorles St. Balto. M. 2120 X	4 6	OL	0	Server									
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29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) Ag UST 26, 20 30. Name any address of person who completed cause of death se 23a) (Type, Print) Wift (E. C. Ley G. Line & W. Chorles St. Balto. Md 2120)	plete	edi	one)		and manne	r stated.		ostigation, in my	opinion, death of	curiou at the time,	date and plac	e, and due to	trie cause(s)
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Amend items 7,8 per fh 2847 9-6-05 vt.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

Reg. No. 2005 1 - For State Registrar 28858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08.23 **Physician** Year STEWART JACKSON 1555 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MERCY MEDICAL CENTER BALTIMORE NA 8. Date of Birth 1928 (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Funeral Birthplace (State or Foreign Country) 1**№** M 2□ F 78 Yrs. Months Days Hours 216.20.6226 Director MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event. The Madical Expriment must be multified at MD NA Baltimore Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 21223 21det Lauretta USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 nd Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Yellow Cab Dispatcher 12th grade 17. Father's time (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental ! Rufus Jackson Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez Jackson (WIFE) 2664 Lauretta Ave Balto. MD 21223 item 27 I Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ξ ö permit. Page Department of Important: If any injury or once. 09.01.05 DWING MILLS MD Garrison Forest *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Vaughn C. Greene Funeral Service 515 JBalto. Nat'l Pike Balto. MD 21229 anch 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CARDIORESPIRATORY ARREST Physician MIN /Medical Due to (or as a consequence of) **Examiner** ARTERY 35 MIN CORONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of): physician Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify). the o detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed END STAGE REVAL DISEASE DIABTES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2/2 No certificate HYPERTENSION 1 ☐ Yes 2 No 1 Tes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No
27. Manner of Death
1 Natural examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide thin 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within ? 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 0 KFS 000 AUGUST 23.2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALJEET S. UPPAL MERCY MEDICAL CTR. BALTO, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State See Es Registrar SEP 0 6 2005

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68760, <	Ų.	
s, P.O. Box	aw requires that the death certificate be executed	
al Records	: The la	
vision of Vital Records, P.O. Box 68760,	Attending Physician ar death.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28859 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 30,2005 JAMISON CURTIS 2:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD Gamaritan Hospital NAtimore par | Hunder 24 Hrs. 5. Social Security Number Mn yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1**☎** M 2□ F Hours 250-22-0711 Director 01-15-1925 SC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at MD BALTIMORE Director 1 ☐ Yes 2 No GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a AVENUE 3303 DAKFIELD 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ¥Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) CORRECTIONAL OFFICER 12 TH GRADE PATUXENT INSTITUTE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JEHU JAMISON UNDSEY GEIGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 3303 OAKFIELD AVE. MARY JAMISON (WIFE BALTO. MO 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREENMOUNT 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE /au 5151 BALTO. NATL' PIKE, BALTO. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sician Sepsis edical Due to (or as a consequence of): miner Intection Tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Neumonia attending physician Mellitus Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Cereboorascular Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Decubitus 1 ☐ Yes 2 17 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062239 August 31,2005 30. Name and address of person who comp 'e o u of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd, Baltimore, MD 21239 00 Naina . Regis ar's Signature State

DHMH 17 Rev 1/2001

Registrar

				State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 2 0 0 5 2 8 8 6 0
	45	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 9: 05 A M
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		Funeral		5. Social Security Number (Sex I. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Country) Months Days Hours Min.
		Director		5. Social Security Number 223 · 34 · 444 Usual Residence of Decedent 4. Sex 1 M 20xF 1. Age (In yrs. last birthday) 11 Under 1 Year 1f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 30 30 30 30 30 30 30 3
		laryland show	or	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1DYes 2 1800
		ith the Marylan or 28a-1 show	Jirect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
		death with the Maryland rms 23e or 28e-1 show Frnust be notified at	Funeral Director	7 Sudbrook Lane 21208 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
	36	rs after i', or ite	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 1 Yes 2 No Specify: Specify: 1 Yes 2 No Specify:
5	15-00	"natura		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Vivian	2121	d within giene. er then	Completed	Elementary/Secondary (0-12) College (1-40r5+) Private Duty Nurse Healthcare
>>	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importants if item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinatment be notified at once.	To Be	17. Father's Wame (First, Middle, Last) UNK. 18. Mother's Name (First, Middle, Maiden Sumame) Hatie Waters
è	Mary	d 2 shouth and h		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 House of Course of
nosuyo		of Heal of Heal of other		Twinvelta Gruber grand daughter 12 Hanna Court Windsor Mill MD 21244 20a. Method of Disposition Date 20c. Location - City or Town, State
ON	altimore,	nit. Pag artment ortant: injury c		4 Donation 5 Other (Specify) Greenmount 09.01.05 Baltimore 190
j	B	permi Depa Impo		21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Yaughn C. Greene Funeral Services 5151Baltimore Nat'l Pike Balto MD 21229
4		Physician		23a. Pall T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition
		/Medical Examiner		resulting in death) Due to (or as a consequence of):
	1/	pe și	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):
	v o	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
	68760,	ficate be physicials the bu	edical	d
		Attending Physician: The law requires that the death certifind chain. In death. In death. In this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
	P.O.	at the de by the a	hysic	1 Yes 2 (No 9 Unknown 9 Unknown 9 Unknown
	Division of Vital Records, P.O. Box	w requires that been signed should be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	Seco	e law requ has been je 2 shouli	Completed	Diabetes mellitus 24a. Was an autopsy findings available prior to completion of cause of death?
	ital	ician: Th certificate rector, pag	Be Co	Chrom C Ohstructive pulmonary disease 1 yes 20 No 1 yes 20 No 25. Was case referred to medical examiner?
	of V	Physic or this ce oral dire	ပ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
	sion	Attending I death. ctor: After y the funer	Certification;	2 Accident investigation M 1 Yes 2 No
	Divi	tal or Al	Certif	4 Homicide determined determined building, etc. (Specify)
		To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
4		To th Withir To th comp	×	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PAS - 1907 Southenber 1 2005
		1		30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)
	5	Sta	te	City Huars MD Since Hospital of Battimore 31. Date filed (Month Pay Year) 32. Registrar's Signature
	3	Registi		SEP 0 6 2905 Seems A Apartho

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month D9 7:30 AM Primus Jones 01

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Baltimore

Hours

Min.

4c. County of Death

9. Birthplace Country)

(State or Foreign

10d. Inside City Limits

1 **X**Yes 2 □ No

Date of Birth (Month, Day, Year) 03.30.1930

Physician /Medical Examiner

Director

Completed by Funeral

Be

1 - State Registrar

5. Social Security Number

212.26.5118

MD

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

3752 Old Frederick Road

1**X**M 2□ F

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at

Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes.

Baltimore, Maryland 21215-0036

Pnysician /Medical

Examiner Physician/Medical by Completed Be ို Certification;

31. Date filed (Month, Day, Year)

SEP 0 6 2005

29a. Certifier

Medical

State Registrar

Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed this After t death. within 24 hours after death To the Funaral Director:

Division of Vital Records, P.O. Box 68760,

10e. Street and Number 3752 Old FVC	terick Road	10f. Zip Ci	21229	10g. (Citizen of What Country?
11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was Deceder	t of Hispanic Origin? (S	Specify Yes or No-	14. Race - American Indian,
1 ☐ Never Married 2 ⚠ Married	Armed Forces? 1 ☐ Yes 2 ▼No		Cuban, Mexican, Puer	to Hican, etc.)	Black, White, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 2	No Specify:		Specify: Black
15. Decedent's Edu (Specify only highest grade	e completed)	16a. Decedent's Usual (Give kind of work of the DO NOT use	occupation done during most of wo retired)	rking 16b.	Kind of Business/Industry
Elementary/Secondary (0-12) LHN, grade	College (1-4or 5+)	Contr			ome Improvement
17. Father Name (First, Middle, Last) Primus Jones, St	^.		18. Mother's Nat	me (First, Middle, Maide Thompson	n Sumame)
19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Address (S	treet and Number or R	ural Route Number, City	or Town, State, Zip Code)
Hazel Jones / Wi	ife	3752 dd	Frederick	Rd. Bal	to. MD 21229
20a. Method of Disposition	1 0	lace of Disposition (Name emetery, crematory or other	of or place)	Date 20c.	Location - City or Town, State
1 Surial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State	Arbutus	09.		altimore, MD
21. Signature of Funeral Fely ice Licensi	For	22. Name and Vaughn 5151 Bak	Address of Facility C. Greene Fi Honore Nat	uneval se Ibnal Pike	vices Balto.MD 21229
23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ications that caused the death				Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Ventric	ulas F	Will	aton	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	as toly	dise	arctar	Bewmin to Several pos
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic preg			23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the underlying caus	se given in Part I.	23e. Did tobacco	use contribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 DNo
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	fospital: 1 Inpatient 2 I	ER/Outpatient 3 DOA	Other: 4 Nursing H	lome 5 esidence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Injury at Work? 1 Yes 2 No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, o	ffice	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)

7. Age (In yrs. last birthday)

75 Yrs.

10c. City, Town or Location

Baltimore

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Amend item 19b per in 8847 9-9-05 vt. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 0 0 5 28862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jean O. Jolley September 2, 2005 9:05 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase
If Under 1 Year If Und
Months Days Hour 8100 Connecticut Avenue #321 Montgomery 9. Birthplace (State or Foreign Country) North Dakota If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 23, 1909 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. 1 □ M 2 🔀 F 545-20-9141 96 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or then "naturel", or iteme 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Montgomery Chevy Chase Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8100 Connecticut Avenue #321 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental Fire marked of Clara Leyse Jourgen Olson Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bethesda 19a. Informant's Name/Relationship (Type, Print) Health Item 27 Susan J. Waldrop/Daughter 9210 Laurel Oak Drive, Chevy Chase, MD. 20817 other 20b. Place of Disposition (Name of Montgomery crematory or other place) Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State September 4, 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury or once. Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Robert A. Pum Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-3501 Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee M01353 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Gastrointestinal Bleeding one day /Medical Due to (or as a consequence of): Examiner Respiratory Distress four hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physicien and use as the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🌠 No Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached o. 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Osteroporosis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Failure to Thrive 24a Wasan page 2 s certificate 1 Yes 2X No of Vital After this certification funeral director, I or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Division 1 XNatural 5 Pending To the Hosping.
within 24 hours after death.
To the Funerel Director: Aft 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 960

State Registrar

31. Date filed (Month, Day, Year)

Raman R. Tuli, M.D.,

SEP 0 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

allhah



10810 Darnestown Road, Suite #202, Gaithersburg, MD. 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28863 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** September 4. 2005 2:45 Jeanette Albert Kleiman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 725 Mt. Wilson Lane, Apt. 403 Pikesville Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year)
Aug 18, 1921 Connecticut Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕶 F 095-12-9853 84 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f ehow ury or other traumatic event, If a Medical Exarchmet is neather an Inflied at 1 ☐ Yes 2X No Director Pikesville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 Mt. Wilson Lane, Apt. 403 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Albert Frieda UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth B. Kleiman, Daughter 5701 N. Sheridan Road, Apt. 27-J Chicago, I1 60660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Metro Crematory Inc. 09/06/05 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Vancular Disease ro sclerati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed buriai-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending Injury 5 Pending thours after death.

-uneral Director: After the further of the further the fu 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29c. License number Ne of certifier 29b. Signatu e and t

Registrar

State

30. Name and address

31. Date filed (Month

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2005

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of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

MESHULAM

29d. Date signed (Month, Day, Year)

September 6, 2005

PL \$605

BAYTHORE MD 21202

State of Maryland / Department of Health and Mental Hygiene 2005

28864

		1 - Stata Registrar	State of Marylan	Cei	tificate of	Death	F	Reg. No.	
Physic /Medi		Decedent's Name (First, Middle, Last	1)		KEN	NDLE	2. Date of Dea Month SEPTE mi	Day Y	ear 14:48 M
Exami		4a. Facility Name (If not institution, give	street and number) NS HOSPITAL		_	r Location of Death	n	4c. County of	
Funeral Director		5. Social Security Number 6. Se 212-96-1327			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 15,	Year) 9	. Birthplace <i>(State or Foreign</i> <i>Country)</i> Maryland
e Maryland Je-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince		y. Town or Lo aurel	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with th	Funeral Director	10e. Street and Number 15518 Plaid Drive			10f. Zip Code 2 0 7	07		10g. Citizen of Wha	at Country?
If I I I I I I I I I I I I I I I I I I	þ	11. Marital Status XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛛 🔏 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race- Black, Specify: V	American Indian, White, etc. Vhite
in 72 ho	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Deced (Give life.	tent's Usual Occup kind of work done DO NOT use retired	pation during most of wor d)	rking	16b. Kind of Busin	ness/Industry
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and 2 sho and 2 sho salth and P n 27 le ma	ľ	19a. Informant's Name/Relationship (7) Ersilia Lappa /	ype, Print) mother		ng Address <i>(Street</i> 3 Plaid D		ural Route Numbe	r, City or Town, Sta rvland	ate, <i>Zip C</i> ode)
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depurtment of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or Iteme 23e or 28e-1 ehow any jury or other treumatic event, the Medical Exarts at must be positived at one.		20a. Method of Disposition 1	20b. P Removal from State Entombment C	lace of Dispo emetery, cren Cathedr 22	sition (Name of natory or other place al Cemet Name and Addre Onaldson	ery 09/0 ss of Facility Funeral	Date 08/2005_ Home, P	20c. Location - Cit	yorTown,State
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ER BRAL Due to (or as a consequ	Vascu	IAR Acc		or respiratory ari	rest,	Approximate Interval Between Onset and Death
rificate be executed ng physician and as the burial-transit	Medicai Examiner	Sequentially list conditions, fany, bearing to him adata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence	uence of):				-	
The Coulds, F.C. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnancy	,		23d. Date of Month	f delivery Day Year
requires that reen signed be detailed.	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ite to the cause of death? Probably 4 Unknown
VICAL DECO vicien: The law re certilicate has be rector, page 2 sho	Completed						24a. Was a autopo perfor	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
ysicien: 'ysicien: 'ysicien: 's certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo	Hospital:	ER/Outpatien	t 3 DOA Oth	05	th (Check only or	ence 6 Other	Specify)
To the Hospitel or Attending Physicien: The Within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			ow injury occurred	
el or Atte s after de sl Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (S City or Town		or Rural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ti	edicai (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of my kno- iner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manne late and place, and	er as stated. due to the cause(s)
To the within to the company of the the company of the the company of the the company of the the the the the the the the the the	M	29b. Signature and title of certifier	HEDICAL DOCTO	R	29c. Licens	- 000		29d. Date signed (A	Month, Day, Year)
10.		30. Name and address of person who co	ompleted cause of death (Item	HOSPITAL	- Loo No	RTN Ware	_		
St Regist		31. Date filed (Month, Day, Year) SEP 0 6	32. Registrar's Signa	ture /	parles			LACT ITEM	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien200528865 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Katherine Elizabeth Keller September 2005 $0450 \text{ A}^{\text{M}}$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Havre de Grace Harford Harford Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√2 F 98 Yrs. Director 216-09-8643 1906 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Harford Directo Maryland Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ould be filed within 72 hours after deeth with i Mental Hygiene. ö 105 Orsburn Drive 21085 **USA** Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No White Specify: 3 ₩idowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h end Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Magdalene Peterson John Henry Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 end 2 s item 27 Eleanor J. Baker/Daughter 105 Orsburn Drive, Joppa, MD 21085 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of Important: if it any injury or o once. 1 🙀 Burial / 2 🗌 Crémat 3 Removal from State 9-7-05 Oak Lawn Cemetery Baltimore, MD * 4 ☐ Dohation 5 ☐ Other (Specify) 21. Sign rure of un 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PIVATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 Probably 2. No 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 340 1□ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1ª Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the I

Registrar

29b. Signature and title of certifier

30. Name and address of person who

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Year)

mplete carse of death (Item 23a) (Type, Print)

32. Registrar s Signature

29d. Date signed (Month, Day, Year)

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2005

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Fune Direct			5. Social Security Number 213 36 3882 Usual Residence of Decedent	6. Sex 7. Age (In yrs. 11	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)		Birthplace Country)	e (State or Foreign
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± 5 ± 5	- 16	2	1 Yes 2X No 27. Manner of Death	1 Anpatient 2 L	ER/Outpatient 28b. Time of	3 DOA Othe	4 LI Nursing H	lome 5 Resid			Specify)	
th.			1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year)	Injury	Work	rat ?? Yes 2 □ No	28d. Describe h	ow injury	y occurred		
To the Hospital or Attending P within 24 hours after death. To the Funaral Director: Attent completely filled in by the funera		Ceruncation	3 Suicide 6 Could no 4 Homicide determin	t be	me, farm, stre			28f. Location (S. City or Town	treet and n, State)	d Number o	r Rural Ro	ute Number,
e Hospite 124 hours e Funara letely fille		ealcal	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of my know caminer: On the basis of examinati and manner stated.	wledge, death ion and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occu	a, and due to the curred at the time, d	ause(s) ate and	and manne place, and	r as stated due to the	cause(s)
To th within To th comp		M	29b. Signature and title of certifier			29c. License	number	2	9d. Date	e signed (M	onth, Day,	Year)
· or			* Ashi	m >.		Do	05143	37		Of:	30:	2005
21			30. Name and address of person when AAMC 200			Print)	NAMPL	1 WDIK	01	DA-	(4)	1317075
	State		31. Date filed (Month, Day, Year)	32. Registrar's Signati		59 £	1 - 4 - 4 - 4 - 4 - 4 - 4	م بمدن ،	-	9,116	-//	3.10 /2
Regi	istra	r	CEDAG	2005	M Da	CAR!						

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			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of Health tificate of Deat	n and Mei th		ene 200	5 28867
П	Physici	an	Decedent's Name (First, Middle, Last Joan	Dale	Ly]	es	2.	Date of Death Month	27 2005	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		27	4b. City, Town, or Location	on of Death	0	4c. County of Dea	12.39 p
	LAGIIIII	C1	3901 Wabash	Ave. Apt	2 A	Baltime			NΑ	
	Funeral Director		5. Social Security Number 6. Se 218–42–3494 10 Usual Residence of Decedent	7M 2XE	(In yrs. last birthday) Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. rs Min.	Date of Birth (Month, Day, Y 6-15-	9. Bi 1944	rthplace (State or Foreign country) Va
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Be-f st	Director	Md	N/A	Balto					1 XYes 2 □ No
	with the or 2	Dire	10e. Street and Number	muo Amt 2	A	10f. Zip Code	_		. Citizen of What C	country?
	death ms 23	Funeral	3901 Wabash Ave	12. Was Decedent Ev	ver in U.S. 13. V	2121. Vas Decedent of Hispanic	Origin? (Specif	v Yes or No-	USA 14. Race - Am	
Maryland 21215-0036	hours after death with the Maryland turel', or Items 23e or 28e-f show all Examiner must be notified at	by	Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:)	Yes, specify Cuban, Mexi		an, etc.)	Black, Wh	ite, etc. B1ack
15-6	72	lete	15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual Occupation kind of work done during ri DO NOT use retired)	nost of working		b. Kind of Business	·
212	d within giene. rr then "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) [/A	Counselor		R	ehabilita	tion Clinic
nd	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)					irst, Middle, Ma	iden Sumame)	
ryla		ဂ္	James Silas 19a. Informant's Name/Relationship (T)	(na Print)	10h Mailie	g Address (Street and Nur	ary Lyl		No. of Table Control	7-011
	nd 2 ilith a 27 lg		Michael Lyles - So			Curning Leaf				zip Code)
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date	20	c. Location - City o	r Town, State
ţi	Pa nen ent: ury		'4 Dpnation 5 □ Other (Specify,			norial Park	9-3-20		andallsto	
Ba	permit. Departr Importe any Inj		21. Sonature of Funeral Service Ucens	Shampa	in	Name and Address of Fa March F. H	. West	4300	imore,Mo Wabash	
			23a. Part I. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused the cause on each line	300 4 0	7 0232	as cardiac or re	espiratory arrest	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	aN Due to (or as a	6 CAN consequence of):	ICER				ONE YEAR
H	Examiner		Sequentially list conditions,	HUMA	N IMMU	NOCEFICIE	NCY 1	HERUS	•	13 YEARS
T	led nsit	Examiner	Tany, leading to animodiate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	noneaquence of):				1	
V	icate be executed physician and s the burial-transit	Exan	that initiated events resulting in death) Last	Due to (or as a	consequence of):			·		
68760,	licate be physicia s the bur	edical		d		- <u> </u>				
			IF FEMALE:	23c. If yes, outcome of	f prognaggy				1	
Box	atte for	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O.	that the de led by the a	hys	9 Unknown	9□ Unknown						
	ires thai signed b	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	iderlying cause given in Pa	urt I.			o the cause of death?
COL	w requir been s should	leted						24a. Was an		
Re	The law ate has b page 2 st	ompl						autopsy performe	d? prior to death?	utopsy findings available completion of cause of s
Vital Records,	cien: T ertificati ector, pa	BeC	25. Was case referred to medical examiner?			26. Pla	ace of Death (C		No 1 L Ye	SZALNO
of/	Physicien: r this certific ral director,	٠ <u>۲</u>	1 ☐ Yes X No 27. Manner of Death	Hospital: 1 ☐ Inpatient				Residence Describe how	e 6 Other (Spe	ecify)
	Attending or death. ector: After by the funer	atlon:	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2		. Describe now	injury occurred	
Division	or Attendate death Director: in by the	Certifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	28f.	Location (Stree City or Town, S		tural Route Number,
	pitel o	al Cei	20a Cartifiar Marchine Bhu	niniana Tauta tauta d						
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by ti	edica	29a. Certifier Certifying Phy (Check only one)	ner: On the basis of e and manner state	examination and/or inv	occurred at the time, date restigation, in my opinion, o	and place, and death occurred a	at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier			29c. License numbe	er	29d	. Date signed (Mon	th, Day, Year)
•	. 1		1 fell	MD		RES-OC	00	Au	GUST 30	, 2005
	H		30. Name had didness of person who call the state of the	ompleted cause of dea	ath (Item 23a) (Type,	Print)	SALT-	100 m L	14014 141	D 21771
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	RES-OC Print)	THE TAKE	wein	TEYLANV.	U &1 & 5
	negisti	aı	SEP 0 6 21	OUD CON	J 15 /5	45-65-				

		- For Amend Item16 Registrer			'Cer	tificate of	Deāth -				
Physici	an	Decedent's Name (First, Middle, I Willie	.ast)		_			2. Date of De Month	Day	Year	3. Time of Death
/Medic	al			-1		awhorn		August		2005	11:37 A
Examin	er	4a. Facility Name (If not institution, g 1115 Brentwood Ave.	ive street and number	")		4b. City, Town, or Baltimore	Location of De	atn		nty of Deatl IA	h
Funeral			Sex 7. A	ige (In yrs. last t	birthday)	If Under 1 Year	If Under 24 H		th		hplace (State or Fore
Director		216-80-3968	X □M 2□F	43	Yrs.	Months Days	Hours M	n. (Month, Da 5-7-	62 Year)	Co	Md.
<u>p</u>		Usual Residence of Decedent		T							
larylan ahow	_	10a. State 10b. County		10c. City, To							10d. Inside City Lim
r 28a-f ahov	Directo	Md. NA			Baltin						1 X Yes 2 □ N
th with t	ai Dir	10e. Street and Number 1115 Brentwo	od Ave.			10f. Zip Code 212	202		10g. Citizen o	of What Co	untry?
72 hours after deeth with the Maryland Instural; or Itams 23a or 28a-f ahow Incal Examinational be notified at	l by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	? No		Vas Decedent of H Yes, specify Cuba	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Spec	lack, White	ncan Indian, e, etc. lack
72 h	etec	15. Decedent's (Specify only highest of		16	(Give I	ent's Usual Occup	furing most of w	rorkina	16b. Kind of	Business/l	ndustry
han .	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	life. D	ndyman)	-		Varie	s
should be filed v nd Mental Hygie s marked other ti umatic avant, III	Be	17. Father's Name (First, Middle, La: James	E.	Ţ	awh	orn	18. Mother's N	ame (First, Middle	, Maiden Sum	ame)	
d 2 should th and Men ?? is marke traumatic	٦ ا	19a. Informant's Name/Relationship						Rural Route Numb	er. City or Tow	n State 7	in Code)
7 4 8		Harry Scott	Frie					e., Balti			21202
Fits of H		20a. Method of Disposition 1 Burial 2 □Cremation 3	☐Removal from State	e cemet	tery, crem	sition (Name of patory or other place		Date	20c. Location		
permit. Pag Depertment Important: any Injury o	1	4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		ME		Name and Address		·3-05 Balti	Dund more, M		ма. 21202
9 9 E 8 9	5 4	& lade	o wa	لىمىر	4	March F	'.H. Ea		1 E. N		
Prici pe	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	c	s a consequence							
ificate phys	edic		u								
at the death certific by the ettending p tached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Petal deat at time of death		Ectopic pregnancy Other (specify)				Date of deliversity	very Day Year
		Part II. Dther significant conditions	contributing to death	but not resulting	in the un	derlying cause give	en in Part I.		obacco use co Yes 2⊠No		the cause of death?
he law e hes b	Completed								rmed?	o. Were aut pnor to co death?	opsy findings availab ompletion of cause of
ician: T certificet rector, pa	Bec	25. Was case referred to medical					26. Place of D	eath (Check only o	2 No	es es	2 No
Ğ .∞ 'ō	To	examiner? 1 ∰ Yes 2 ☐ No	Hospital: 1 Inpat	ient 2 ER/C	Outpatient	3□ DOA Othe		Home 5 ☐ Resid		ther (Speci	ity) Scene
5 F 5		27. Manner of Death 1	28a. Date of Inj (Month, Da	ury 28b. ay Year)	. Time of Injury	28c. Injury Work		28d. Describe I			<i>,,</i> , , , , , , , , , , , , , , , , , ,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not determine	d 286. Place of in	njury - At home, tc. (Specify)	farm, stre	et, factory, office		28f. Location (City or Tou	Street and Num wn, State)	nber or Rur	al Route Number,
a Hospit 24 hour a Funera letely fille	edical	29a. Certifier 1☐ Certifying F (Check only one) 2☑ Medical Extended	Physicien: To the best eminer: On the basis and manner s	of examination a	ge, death and/or inve	occurred at the timestigation, in my or	e, date and pla inion, death oc	ce, and due to the curred at the time,	cause(s) and r date and place	manner as :	stated. to the cause(s)
To the withing the the the the the the the the the the	Me	29b. Signature and title of certifier 30. Name and address of person wh	o comple ed cause of			*	Е.		29d. Date sign August Ol	19, 2	
		31. Date filed (Month, Day, Year)	/ 1 / 0	trar's Signature	111 DL	LUL, DILL	الطاوعالماني	yıcılı 212	ΛΤ		

_		ľ	For State Registrar		of Marylar	nd / Dep <i>Ce</i>	artmen rtificat	t of H e of L	ealth a Death	nd Mental	Reg. No.		28869
	Physici /Medic		Decedent's Name (First, Middle NATHAN)			L	EVY			2. Date of Month	Day	Year	3. Time of Death 5-04:00 A M
7	Examir	er	4a. Facility Name (If not institution	of Bal	tnoce		Bal	hno		ty		County of Dea	N/A
	Funeral Director		5. Social Security Number 213-32-7058	6. Sex 1 M 2 F	7. Age (In yrs.	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. JAN.	f Birth , Day, Year) 1930	9. Bird	thplace (State or Foreign ountry) MD
	within 72 hours after death with the Maryland see. see. see. see. see. see. see. see	tor	Usual Residence of Decedent 10a. State 10b. County MD	BALTIMOF		ity, Town or Lo	cation IMORE						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	10e. Street and Number 11-B PIPE HILL				10f. Zip	Code	2120	o	10g. Citi	izen of What Co	ountry? USA
	er death Items 2%	Funeral	11. Marital Status	12. Was De	ecedent Ever in U		Was Deced	dent of Hi		in? (Specify Yes o Puerto Rican, etc	r No-	14. Race - Ame Black, Whit	erican Indian,
Maryland 21215-0036	72 hours aft "natural", or	b	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes. (Year or	s 2□No AR Give Dates:		1 🗆 Yes		Specify:			Specify:	WHITE
1215-	2 should be filed within 72 hc and Mental Hygiene. Is marked other than "natur eumatic event, the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	st grade completed	d) (1-4or 5+)	(Give	DO NOT u	rk done d se retired	during most)	-		ind of Business	
1/4 Rome/	e filed v al Hygiei s other ti vent, th	Be Co	17. Father's Name (First, Middle,	Last)			KILI	SALE	S MAN	AGEK 's Name <i>(First, Mi</i>			TINGHOUSE
>\ \	should b ind Menti imarked umatice	Jo.	CARL 19a. Informant's Name/Relations	nip (Type, Print)		LEVY	ng Address	(Street a	RAE	r or Rural Route N	umber, City o	r Town, State, 2	POTTER Zip Code)
			MARIAN LEVY -	WIFE	205		PIPE	HIL	L COUI		TIMORE	, MD 21	209
had known	permit. Pages Department of I Importent: If Its any injury or o		1 Burial 2 □ Cremation 1 Donation 5 □ Other (S)	3 □Removal from secify)	m State	cemetery, cre	matory or o	ther plac		9/2/2005		ocation - City or ISTERST	
Patent Baltin	permit. Depart Import any inj		21. Signaturi di Funeral Service	Licensee	1	2	2. Name ar 900 R	d Addres	s of Facility	SOL LEVI	INSON 8	& BROS.	, INC. MD 21208
(7)			23a. Pan . Inter the disease, or shoot or hint failure. List Immedia. Cau (Final	omplications that	t caused the dea each line.							,,,,,,,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	aDue t	o (or as a consec	quence of);			-				2 days
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due t	o (or as a conse	quence of):							
o	cate be executed thysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							**
68760.	the the	edicai		d					····				
Division of Vital Records. P.O. Box	Hospitel or Attending Physicien: The law requires that the death certifice theories after the control of the co	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of pregn birth 2 Peta gnant at time of a known	aldeath 3	⊒Ectopic pr ⊒ Other (sp				_	23d. Date ot dei Month	livery Day Year
a. G	ires that signed b	by Pł	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	inderlying c	ause give	en in Part I.			use contribute to	the cause of death?
ecor	e law require has been si je 2 should l	Completed by	1110131010	Cencer	Ky ner ich	3105				24a. '	Was an autopsy	24b. Were au	atopsy findings available completion of cause of
in the second se	certificate ha	O	25. Was case referred to medical						26 Place	1 ☐ Y	es 20 No	death?	\mathcal{A}
of Vi	Physicien: this certific al director,	To B	examiner? 1 Yes 2 X			ER/Outpatie			ar: 4 🗆 Nur:	sing Home 5□ I	Residence (cify)
nois	ttending P death. ctor: After I	cation	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	te of Injury onth, Day Year)	Injury	М		rat (? Yes 2□N		ibe how injur	y occurred	
Divis	tel or Att s after d el Direct ed in by	Certification;	3 Suicide 6 Could a determ	ined 28e. Pla bui	ce of Injury - At h Iding, etc. (Speci	nome, farm, st ify)	reet, factory	r, office		28f. Locati City o	on (Street an Town, State	d Number or Ru)	ural Route Number,
	To the Hospitel or Attendium within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical (29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To t Examiner: On the and ma	he best of my kn basis of examinanner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my or	ne, date and pinion, death	place, and due to h occurred at the ti	the cause(s) me, date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and the of certified	77/	10	14.)		. License			_	te signed (Mont	
	107		30. Name dress of person	who completed ca	use of death (Ite		Print)		-000			mber I,	2007
	Sta		31. Date filed (Month, Day, Year)	Nelson, 32.	Registrar's Sign	>\	Speed	1765	pitel	of Bal	TMORE		

State of Maryland / Department of Health and Mental Hygienes 28870 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 4, 2005 TERE71A LOVEI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth JUNE 23, Year) 902 9. Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗑 F NONE 103 HUNGARY Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. snt: If item 27 is marked other than "neturel", or Items 23s or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examinar must be rigitized at Completed by Funeral Director 1 ☐ Yes 2 🛛 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 CLIFFDWELLER COURT 21117 HUNGARY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 6 OWN HOME 17. Father's Name (First, Middle, Last) To Be 18. Mother's Name (First, Middle, Maiden Surname) ZSIGMOND DEUTSCH RAKHIL ADLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRANDDAUGHTER 7 CLIFFDWELLER COURT - OWINGS MILLS, MD 21117 SUSAN SMITH / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) **C**CENTRAL CEMETERY 09/08/2005 BUDAPEST, HUNGARY uneral/Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 1 🗆 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No after death Director: Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated 29b. Signature-and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 6 2005 Registrar

	1 - For State Registrar		(ertificate of I	eaim and i Death	Mental Hy		2005	2887
	Decedent's Name (First, Middle, Last)		orimouto or i	Joann	2. Date of D	Reg. No.		3. Time of Death
an	Margaret	L. Mo	cClella	nd		Month Septem	Day her 3	3. 2005	5:30 A
al er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			County of Deat	
	1606 Hog Farm Ro	ad, Apt.	A	Miller	sville		A	nne Ar	undel
	5. Social Security Number 6. Se	x 7. Age ((In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	9. Birt	thplace (State or Fore
	577-42-7243	J.W. 2701	72 Yrs			AUG 12	2, 19		nington, D
	10a. State 10b. County	1	10c. City, Town o	r Location					10d. Inside City Limi
tor	Maryland Anne Ar	undel		Mi 11	ersville				1 □ Yes 2 📉
Director	10e. Street and Number	urger		10f. Zip Code			10g. Citiz	en of What Co	ountry?
<u>а</u>	1606 Hog Farm Ro	ad, Apt. A	1	21	108		I	JSA	
Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		3. Was Decedent of H If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No		4. Race - Ame Black, White	
by FL	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 💆 No	Specify:				White
	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a De	ecedent's Usual Occup	****				
ojet	(Specify only highest grad	le completed)	— (G	ive kind of work done of the DO NOT use retired	turing most of wor	king	I	nd of Business/ dera1	industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		. Treasury	Analvst			uerar vernmen	nt
e l	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle			
0 8	Charles Carlton	Dinwiddie,	Sr.						
	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. M	ailing Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, 2	Zip Code)
	_ David Wayne McCle	11and/Son	160	6 Hog Farm	Road, A	ot. A, N	ille	rsville	, MD 2110
	20a. Method of Disposition 1 ☐ Burial 2 ♥ Cremation 3 ☐ F	Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other place	ө)	Date	20c. Loc	ation - City or	Town, State
	1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Metro C	rematory,		3/05	Ва	altimor	e, MD
	21. Signature of Funeral Service Licent	99 _		22. Name and Address Cremation	s of Facility Society	of MD.	Inc.		
	Edward A/ Gres	orchik		299 Freder	ick Road	Baltim	ore.	MD 2122	-
	23a. Part1. Enter the dise ve, or complete, or heart failure. List only o	ne cause on each line.	ne death. Do not	enter the mode of dyin	g, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)		9 6	1224					
		Due to for ac a f							
- 1		Due to (01 as a 1	equence of):						
e.	Sequentially list conditions, if any, leading to immediate	b	c equence of): consequence of):						
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_	if any, leading to immediate cause. Enter Underlying Cause Clises of the that initiated events resulting in death) Last	Due to (or as a o	consequence of):						
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To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause Clises of the Program of Park It and It also of the Program of Park It. Other significant conditions could be examiner? 25. Was case referred to medical examiner? 1	Due to (or as a of Due to (or as	consequence of): consequence of): pregnancy Fetal death not resulting in th 2 ER/Outpa 28b. Tim Injut / At home, farm, (Specify)	e underlying cause give tient 3 DOA Other e of 28c. Injury Mort street, factory, office	26. Place of Dea P. 4 □ Nursing H at ?? Yes 2 □ No e, date and place	24a. Was auto perfu 1 Yes th (Check only ome 5 X Resi 28d. Describe 28f. Location (City or To	Yes 2 an psy ormed? 2 No one) idence 6 how injury	Month se contribute to No 3 pro 24b. Were au prior to c death? 1 Ves Other (Spec occurred	Day Year the cause of death? obably 4 Unknow topsy findings availab completion of cause of 2 No cify) tral Route Number,

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) 32. Register's Signature SEP 0 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yndhish Markam 305 Hospital W. Glen Burnic, MD

Amend Item 31 State of Maryland 6 Department of Health and Mental Hygienes 28872 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Grace Liebig McKay September 4 2005 6:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 18 Goshen Court Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 92 yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2X□F Months Director 261-92-7411 FEB 11, 1913 North Dakota Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits treumetic event, the Medical Examinar must be notified at Director 1 Yes 2 No Florida Brevard Melbourne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With ō or Items 23a 1278 Rivermont Drive Completed by Funeral 32935 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 XYes 2 □ No 1942-If Yes, Give Year or Dates: 1951 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 🏋 Divorced 1951 'neturel', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Nurse <u>Healthcare</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental t August Liebig Perlia Abigail Bullard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Hornseth/daughter 18 Goshen Court Gaithersburg, MD 20882 rtment of Health other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department Importent: any injury o Metro Crematory, Inc. ^ 4 ☐ Donation 5 ☐ Other (Specify) 9/6/05 Baltimore, MD 21. Signature of Funeral Servicer Livensee

Dawn F. McDonald ²². Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumon. aV resulting in death) /Medical Due to (or as a consequence of) Heart Failure Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events a consequence of) The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy performed Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence Daughter's Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 1 Whatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 T Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) September 4, 2005 Philip#275 olney, MD 20832 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pawn Broderick M.D. 18109 Prince 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 6 2005 State Registrar

			For State Registrar	State of	Maryla		artment of H		Mental Hyg	iene 200	5 28	873
	Physici	an	1. Decedent's Name (First, Middle, Last)	30UN	_	MEVEDO			2. Date of Dear	th	3. Tim	e of Death
	/Medic	cal .	4a. Facility Name (If not institution, give s			MEYERS	4h City Town	or Location of Deat		er 1, 2005		5 p. M
	Examir	ier	Greater Baltimore			er	Towson	DI LOCATION OF DEAT		Baltin		
	Funeral		5. Social Security Number 6. Sex			. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9	Birthplace (Sta Country) MARYLAI	te or Foreign
	Director		Usual Residence of Decedent						00-00-	1923	MAKILA	עו
	darylan f show	ō	MD. State 10b. County BALTIMO	RE	10c. C	ity, Town or Lo		HERVILLE				e City Limits Yes 2 XX No
	th the por 28e-	Funeral Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	it Country?	
	s 23a	erai [515 BRIGHTFIELD	ROAD		115 140.1		21093			S. A.	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked othar then "naturel", or Items 23a or 28a-f show othar treumatic event, the Medical Examination in the rediffied at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed ★★ Divorced	 Was Deceded Armed Force Yes 2 Yes, Give Year or Date 	es? ⊠% °		Was Decedent of F f Yes, specify Cub		Specify Yes or No- to Rican, etc.)		American Indiar White, etc. WHITE	١,
2-0	72 ho natur dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	lent's Usual Occup	pation during most of wo	rking	16b. Kind of Busin	ess/Industry	
21215-0036	within liene.	Completed	Elementary/Secondary (0-12)	College (1-4 4 YEAR			OO NOT use retire MANAGER	d)		POWER TR	ANSMISS	ION CO.
70	should be filed within nd Mental Hygiene. markad othar then imatic event, 112 Ms	To Be C	17. Father's Name (First, Middle, Last)	LARENCE		RS			me (First, Middle, I	Maiden Sumame) LHART		-
Mary	2 shound had and his mail		19a. Informant's Name/Relationship (Type DAVID E. MEYERS	oe, Print) (SON)					ural Route Number		-	10
	Health tem 27 tem 27		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		-	20c. Location - Cit		
imo	Pages nent of ant: If it ury or c		1 ☐ Burial XX Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	ate HI		ERVICE C	ORP. 09-0	06-2005	TOWSON, MA	ARYLAND	,21204
Baltimore,	permit. Page: Department of Importent: If is any injury or once.		21. Signature of Funeral Service License		G.RUT		. Name and Addre		AL HOME,I		YORK F ON,MD.23	ROAD 1204
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that cau e cause on eac	used the dea th line.	ath. Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory arre	est.	Approxi Interval Onset a	Between
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$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events	Due to (or	as a conse	cute	Mua	I ful	url		24	celle
8760,	icate be executed physician and s the burial-transit	ai Exa	resulting in death) Last	Due to (or	as a conse	quence of):		0				
	ificate g physi as the l	edicai	_ d	-								
.O. Box	The law requires that the death certifi te has been signed by the attending f age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outco 1 □ Live birt 4 □ Pregnar 9 □ Unknow	h 2 ∏Fei nt at time of	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date o Month	f delivery Day	Year
ds, P.	luires that the signed by all be detacted	þ	Part II. Other significant conditions con	tributing to dea	th but not re	sulting in the ur	nderlying cause gn	ven in Part I.	23e. Did tob	pacco use contribu		of death?
Records,	law require as been si 2 should t	Completed							24a. Was a		re autopsy findir r to completion	ngs available of cause of
									perform 1 Tes	ned) dea		
Vital	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner?	ospital:	patient 2[☐ ER/Outpatien	t 3 DOA Ott	ner	ath (Check only on Home 5 - Reside		Snacify)	
			27. Manner of Leath 1 Natural 5 ☐ Pending	28a. D te	Injury Day Year)	28b. Time of Injury	28c. Inju			ow injury occurred	Specify	
Division	Attending r death. sctor: After by the fune	ficati	Accident investigation 3 Suicide 6 Could not be	28e. Place o	f Injury - At	home, farm, str	M 1 ==]Yes 2□No	28f. Location (St	reet and Number o	or Rural Route I	Number.
=	tal or A	Certification;	4 Homicide determined	building	, etc. (Spec	eify)			City or Town			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the b On the bas and manne	is of examir	nowledge, death nation and/or inv	occurred at the treestigation, in my	me, date and plac opinion, death occ	e, and due to the caurred at the time, da	ause(s) and manne ate and place, and	or as stated. due to the caus	se(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	UVu	W		29c Licens	3909	9 2	9d. Date signed (1)	fonth, Day, Yea	r)
	13		30. Name and address of person who co	mpleted cause	of death (Ite	om 23a) (Type,	Print)	// 1	<1 6	201	2 4-1	Lanl
	Sta	ate_	31. Date filed (Month, Day, Year)	32. Peg	gistrar's Sign	nature	MITH	Charle	5 JH . K	111.531	SIM	HIIIO
5	Registi		SEP 0 6 20	05	P. Ball	K A						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 28874 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AM Albert T. Marlowe, Jr. Sept. 1 2005 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F Yrs. 218-09-1418 Oct. 21, 1920 Director 84 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Howard Clarksville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13822 Lakeside Drive 21029 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. It and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chief Executive Officer Hamburgers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert T. Marlowe, Sr. Ella R. Decker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health at Important: If Item 27 le any injury or other trau once. Mrs. Nancy Merritt/Daughter 13822 Lakeside Drive Clarksville, Md. 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5XI Other (Specify) Entomb Dulaney Valley Mem. Grd. 9/3/05 Timonium, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) 609 Sta Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Tyes 2 🗆 No death. 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours eft To the Funeral Di Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Partulu m 21234 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 0+1 Londrman 6100)elf Luca 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygienes Reg. No. 2005 28875 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 5:10 P M August 31, 2005 Betty Marie Minton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/10/1941 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 M F 219-38-4596 64 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits 28a-f show other treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20 4819 Richard Avenue 21214 United States or Items 23a death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 Divorced Year or Dates "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fil Department of Health and Mental H Importent: if Item 27 is marked oth eny injury or other treumatic even DDCS. Elaine Canning Robert Varley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hoosier - Daughter 3001 Rosekemp Avenue Baltimore, Maryland 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 09/03/2005 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Loen, be 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 401 South Chester Street Baltimore, MD 21231 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The taw requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physicien Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 X No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2 No 1 Yes 2 No Vital or Attending Physicien: director. 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division 1 XNatural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP Sperte 0 6 2005 Registrar

DHMH 17 Rev 1/2001

AUGUST

State of Maryland / Department of Health and Mental Hygiene 2005

			1 - State Amend Item1&Un Registrar 1. Decedent's Name (First, Middle, Last)	pend Item 2	Ja, proen	tiffcate of I	Death ⁴⁹	2. Date of De		Year	2 0 0 1 0 3. Time of Death
	Physici /Medio			Donald	Maynor,	Jr.		Septemb	er 01,	2005	08:50 A™
,	Examir		4a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
			Howard County Gener	al Hospital		Colum	bia		Но	ward	
	Funeral Director		212-98-9102	M 2 T F	rs. last birthday) 24 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec 15	h y, <i>Year)</i> 5, 1980	Coun	lace (State or Foreign try) laryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10	0d. Inside City Limits
	he Maryli 186-f sho ourled s	Director	Maryland N/A			Ва	altimore		10. 00		1 X Yes 2 □ No
	ath with the 23a or 2		10e. Street and Number 746 Dolphin Street			10f. Zip Code	21217		10g. Citizen o	U.S.A	
21212-0030	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Itam 27 is marked other than "natural", or itsms 23s or 28e-f show other traumatic event, the Medical Evantinar must be notified at	by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 		Was Decedent of H f Yes, specify Cuba t □ Yes 20XNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	lace - Americ lack, White, e	
<u>ا</u>	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupa	ation during most of work	ina	16b. Kind of	Business/Inc	lustry
V	ithin and a second	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done o		9			
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yland	should be filed within 72 h nd Mental Hygiene. marked other than "natu umatic avent, tre Medical	To Be	Donald C. N	laynor Sr.			TO. WOULD STVAIN		enne Bo	,	
Mar	1 and 2 sho Health and Ism 27 is my		19a. Informant's Name/Relationship (Type Catherine Boone Mother	e, Print)		g Address <i>(Street a</i> 6 Dolphin St			•	m, State, Zip	Code)
aitimore,	Pages 1 aunent of Healunt: If itam		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	!		sition (Name of natory or other place Zion Cemet e	:e)	09/09/05		n - City or To sdowne, 1	
Dalt	permit. Pages Department of Important: If it any injury or o		21. Signay re if Funeral Service License	1/50	22	. Name and Addres	rothers Fune	ral Service,	P.A./	14047	
ı			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the de	eam. Do not ent	er the mode of dyin	Itaw Place, B g, such as cardiac	attimore, IVI or respiratory ar	rest,	(1217	Approximate Interval Between
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O. Box a	w requires that the death certificate be executed been signed by the attending physicien and should be deteched for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of predictions of the science o	etai death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year
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<u>a</u>	ysicien: Th is certificete director, pag	Be (25. Was case referred to medical examiner?				26. Place of Deal	h (Check only o	ne)	/	
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	Attending P ir death. ector: After t by the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe h	now injury occ	urred	
DIVISION	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (S City or Tox		mber or Rural	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or in	occurred at the time restigation, in my of	ne, date and place, pinion, death occur	and due to the ored at the time,	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)
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	Torond		30. Name and address of person who cor	npleted cause of death (I	tem 23a) (Type,				-		
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Physic /Med		Decedent's Name (First, Middle, Last) Frances	J.	McGee -	2. Date of Death A Month	Day Year 3. Time of Death 6-13 A	И
Exam		4a. Facility Name (If not institution, give street a Gilchrist N.H.	nd number)	4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimore	
Funera Directo		5. Social Security Number 6. Sex 1 M 2 M	7. Age (In yrs. last birtho	Months Davs Hours Min.	B. Date of Birth (Month, Day, Yea 4-7-2	9. Birthplace (State or Foreig Country) Pa.	ηη
anyland show	7	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o			10d. Inside City Limits 1 ∑ Yes 2 □ No	
vith the M or 28a-f	Director	Md. NA 10e. Street and Number 3108 Fairview Roa		timore 10f. Zip Code 21207	10g. (Citizen of What Country?	
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. It other than "natural", or Itams 23a or 28a-f show event. I'm Medical Evanting must be redified at	by Funeral	11. Marital Status		13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerlo R	ify Yes or No- ican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: Black	
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Maryland 21215-0036 d 2 should be filed within 72 hours all th and Mental Hygiene. to Is marked other then "netural", or traumatic event. In Medical Event traumatic event.	Be Comp	12th grade 17. Father's Name (First, Middle, Last)	ege (1-4or 5+)	Assembly Line 18. Mother's Name		roctor & Gamble	
arylan should be nd Mental markad c	10	George		Franc		E. Hill	
		19a. Informant's Name/Relationship (Type, Printers D. Turner-	niece 40	Mailing Address (Street and Number or Rural 1931 The Alameda Balt 1951	imore, M	y or Town, State Zip Code) ID 21218	
More Pages 1 and of He Int: If iten		20a. Method of Disposition 1 □ Xaurial 2 □ Cremation 3 □ Remova *4 □ Donation 5 □ Other (Specify)	from State cemetery,	isposition (Name of crematory or other place) awn Cem. 9-6-0	_	Location - City or Town, State Baltimore, Md.	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or othan		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	Baltimore	e, Md. 21202	
m goess		23a. Part1. Enter the disease, or complications	that caused the death. Do not	March F.H. East		E. North Ave. Approximate	
Physiciar /Medica Examined		Sequentially list conditions.	ue to (or as a consequence of)	MM,Z S,S		Interval Between Onset and Death	
the death certificate be executed the attending physician and check for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No.	ue to (or as a consequence of): es, outcome of pregnancy Live birth 2 ☐ Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year	
VITAL KECORDS, P.O. I siclan: The law requires that the de certificate has been signed by the a rector, page 2 should be detached it	Completed by Ph	Part II. Other significant conditions contribution	g to death but not resulting in the	e underlying cause given in Part I 2 Nath Tailune		o use contribute to the cause of death? 2 No 3 Probably 4 Munknowr 24b. Were autopsy findings available prior to completion of cause of death?	
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Of Phys rathis	은	1 Yes 2 No Hospital 27. Manner of Death 28a.	1 ☐ Inpatient 2 ☐ ER/Outpa Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at 28	e 5 Residence	6 ☐Other (Specify) jury occurred	
UNISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm building, etc. (Specify)	M 1 Yes 2 No	Bf. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
Hospita 24 hours Funaral	edical C	(Check only 2 Medical Examiner: On	To the best of my knowledge, d the basis of examination and/o d manner stated.	leath occurred at the time, date and place, ar or investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
To the within To the comple	Me	29b. Signature and title of certifier		reith D53 642	29d, C	Date signed (Month, Day, Year) Uf. 282005	
J	P	30. Name and address of person who complete	d cause of death (Item 23a) (Ty	Peran DS3 642 (Peran DS3 642 (Peran DS3 642 (Peran DS3 642	343 B	Atmre 21239	
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 0 6 2	32. Registrar's Signature	& Spelle			
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State of Maryland / Department of Health and Mental Hygieney 28878 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** G Day Jean McKinney 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center
5. Social Security Number 6. Sex 7. Ade (In vis last hi Baltimore Rosedale 7. Age (In yrs. last birthday, Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Days 1□M 2⊠F Hours Months Director 213-36-4372 11/29/1939 65 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Walkern Road 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner / Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental F Farl R. Korns 2 Frances Fearneyhough 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar important: If item 27 is any injury or other trat onca. Robert A. McKinney, Jr. (Son) 8045 Philadelphia Road Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 9/8 2005 N☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licensee MM 1407 Old Eastern Avenue)wikowsk Essex, Maryland 21221 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Cancer to lung **Physician** static disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0/00 CAnce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Cardine the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Respiratory Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2, ► No ō Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ s been significant 4 Dunknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy performed? 1 Yes 2 No 1 Yes 2 No After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗀 Yes 2 No 1 Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitai or Attending 1 Natural 5 Pendina hours after death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 🗋 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 4428 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 9000 Franklin ware Drive Baltimore, Md 21237 Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

1	2	8	8	7	9

			1 - For State Registrer		Certificate of Death		. No.	20013
			1. Decedent's Name (First, Middle, Last	1)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Eugene	Martin		August 2	2005	8:23 P M
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	-	4c. County of Death	
			Washington Advent 5. Social Security Number 6. Se		Takoma Park		Montgomery	lace (State or Foreign
	Funeral Director			74 OF 5	rs. Months Days Hours Mir		64 Colu	lace (State or Foreign itry) mbia, SC
	land ow		10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
	Mary Hary	tor	MD Prince Ge	eorge's College	e Park			1 Yes 2 No
	or 28g	lrec	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cour	itry?
	23a 23a	ral	9800 Cherry Hill		20740		United Sta	tes
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. If a Medical Exactinat notal be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue □ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
5-0	72 hc	eted	15. Decedent's Edu (Specify only highest grad	ucation 16a.	Decedent's Usual Occupation (Give kind of work done during most of wi life. DO NOT use retired)	orking 16	b. Kind of Business/Inc	dustry
121	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				
2	filed with Hygiene. other than	e Co	12 17. Father's Name (First, Middle, Last)	08	arpenter 18. Mother's Na	ame (First, Middle, Ma	rivate	
an	d be ental ked o	To Be	Fred Thomas Mart	in	Betty		,	
ary.	2 should be f and Mental h is marked of aumatic ever	-	19a. Informant's Name/Relationship (T)		Mailing Address (Street and Number or F		City or Town, State, Zip	Code)
	1 and 2 Health a tem 27 is		Fred Martin (Bro	other) 5	123 Crittenden St	Hyattsvil	le, MD 207	81
ore	of He filter r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	comoton	Disposition (Name of r, crematory or other place)	Date 20	c. Location - City or To	wn, State
Ĕ	Pag ment tent: t		'4 □ Donation 5 □ Other (Specify)	Fort L	incoln Cemetery 8/		rentwood,	
Baltimore,	permit. Pages: Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Livers		22. Name and Address of Facility F 3401 Bladensburg R			
П			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the death. Do none cause on each line.	ot enter the mode of dying, such as cardia	ac or respiratory arrest		Approximate Interval Between
	Physician	\$ I)	Immediate Cause (Final disease or condition	. Esophaceal	Voriceal &	pleadin	9	Onset and Death
	/Medical Examiner		resulting in death)	Due to was a consequence of		0		
		7	Sequentially list conditions,	b. Al Coholi C		· ·		
V	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hopatic	ence Phalan	BHIN		
,	execun and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a consequence of	f):			`
68760,	tificate be executed g physician and as the burial-transit	cal		d				
	ntifica ng ph s as th	Medical	IF FEMALE:					
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
Ω.	res that the igned by be detact		Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
Records,	quires in sign uld be	ed by				1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Unknown
000	aw requir is been si 2 should I	Completed				24a. Was an	24b. Were autor	osy findings available inpletion of cause of
Ä	The lav	E O				autopsy performe 1 ☐ Yes 2 ☑	d?_ death?	2 No
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Place of De	eath (Check only one)		
of V	Physicien: r this certific ral director,	2	1 □ Yes 2 □ No	Hospital: 1 ☐Inpatient 2 ☐ ER/Out			e 6 Other (Specify)
ou c	fing After fune	lon:	27. Manual of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. To	ime of 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how	injury occurred	
Division	the the	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At home, far		28f. Location (Stree	et and Number or Rura	I Route Number,
Ο̈́	ital or A irs after ral Dire led in b	Certification;	4 Homicide	building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 ☐ CertifyIng Phy (Check only 2 ☐ Medicel Exami	rsicien: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the caus curred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	10000	29c. License number	290	Date signed (Month, I	Day, Year)
1			1000	9714	17424	+1	8127	103
	1		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print) m. D WO	thing to	n Adv	Hers
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Carles			

			Registrar	and / Department of Health and Mer Certificate of Death	Reg. N	lo																
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) GRACE MCCAIN 4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITA	4b. City, Town, or Location of Death	ioust .	ay Year 3. 7 me of Death 2005 3. 20 PM c. County of Death NA																
3	- Funeral Director		5. Social Security Number 6. Sex 7. Age (In y 1 M 2 M F 82 Usual Residence of Decedent	rs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year • 210 • 197	9. Birthplace (State or Foreign Country)																
	he Maryland 8a-f show culling at	actor	MD NA BI	City, Town or Location ALTIMORE		10d. Inside City Limits 1 (♣Yes 2 ☐ No																
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 820 S. CATON AVE 1. Marital Status 1 □ Never Married 2 □ Married 1. Marital Status 1. □ Never Married 2 □ Married 1. □ Yes 2 1. □ Yes 3 1. □ Y	If Yes, specify Cuban, Mexican, Puerto Rica		itizen of What Country? USA 14. Race - American Indian, Black, White, etc.																
215-0036	thin 72 hours e e. en "naturel", c Medical Ever	Completed by	3 Midowed 4 □ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) □ Dementary/Secondary (0,12) College (1-4or 5+)	1 ☐ Yes 2 ☑ No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. l	Specify: BLACK Kind of Business/Industry																
Maryland 21	should be filed wind Mental Hygien in marked other th	To Be Con	7 TH GRADE N A 17. Father's Name (First, Middle, Last) ADOLPHUS WILLIAMS	SENIOR COMPANION 18. Mother's Name (F) ANNIE N	irst, Middle, Maide	LTO. CITY In Sumame) YPKINS																
_	les 1 and 2 sho of Health and I If Item 27 is me			1 K Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	BALTO. N																
Baltimore,	permit. Pag Department Important: i any injury o		4 Donation 5 Other (Specify) 21. Signature of Fune a Service Licensee	VAUGHN C. GREENE FU 5151 BALID. NATU PIKE		LTO. MD ERVICE MD 21229																
68760,	Physician: The law requires that the death certificate be executed X X X X X X X X X X X X X X X X X X X	Completed by Physician/Medical Exa	Completed by Physiclan/Medical	by Physiclan/Medical	Completed by Physician/Medical	Completed by Physiclan/Medical	23a. Part1. Entay the disease, or complications that caused the dishock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	eath. Do not enter the mode of dying, such as cardiac or recovered by the sequence of): AGE RENAL DISEA is a sequence of):	spiratory arrest,	Approximate Interval Between Onset and Death DA YS												
P.O. Box (the death certifica y the attending ph iched for use as th						Completed by	Completed by	Completed by	ysiclan/Me	ysiclan/Me	ysiclan/Me	ysiclan/Me	ysiclan/Me	ysiclan/Me	ysiclan/Me	ysiclan/Me	ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	w requires that the de been signed by the a should be detached f									Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?									
of Vital Records,	ician: The law certificete has b ector, page 2 sl										25. Was case referred to medical	26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
Ϋ́	nysici nis cer I direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	Other		6 ☐Other (Specify)																
Division o	Attending or death. ector: After by the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury	M 1 ☐ Yes 2 ☐ No thome, farm, street, factory, office 28f.	Describe how injude Location (Street a City or Town, State	and Number or Rural Route Number,																
Ö	oltal or urs efte eral Dir		3,			,																
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	29a. Certifier (Check only one)	knowledge, death occurred at the time, date and place, and ination and/or investigation, in my opinion, death occurred a	due to the cause(s t the time, date ar	s) and manner as stated. nd place, and due to the cause(s)																
	To th withir To th comp	Me	29b. Signature and title of certifier Lowse Windheritz	MD 29c, License number P17602	29d. Da	ate signed (Month, Day, Year) GUST 29 H, 2005																
	4		30. Name and address of person who completed cause of death (I LARYSA KWINTKIE WICZ, 900	MD P17602 tom 23a) (Type, Print) CATON AVENUE, BALT	IMORE	MARYCAND 2122																
	Sta	6	31. Date filed (Month, Day Year) 32. Registrar's Si	gnature fe forestel																		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2005

28881

			For State Registrer 1. Decedent's Name (First, Middle, La		Ce	rtificate of		2. Date of D	Reg. No.	0.5	2 0 0 0 1	
	Physici		William H. Mix,			Month Sept		05 ^{ear}	5:30PM			
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				or Location of Death	1		ty of Death Harfor		
Ī	Funeral Director			Sex 7. Ag	e (In yrs. last birthday 82 yrs.	Months Days		8. Date of Bi	irth ay, 1 923	9. Birth Mar	place (State or Foreign ntm) y Land	
036	Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltin	ore	10c. City, Town or L Arbutu						10d. Inside City Limits 1 ☐ Yes 2X No	
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 920 Courtney Rd.			10f. Zip Code 21:	227		_	U. S. A.		
	be filed within 72 hours after death with the Maryland nia! Hygiene. sd other than "natural", or Itams 23a or 28a-f ehow evant, the Marical Examities and the notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐XNo	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	o- 14. Ra Bli Spec	ice - Ameri ack, White,		
Maryland 21215-0036	ithin 72 hc ne. nan "natur nan "natur	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or t	(Give	ecedent's Usual Occupation live kind of work done during most of working te. DO NOT use retired)		king	16b. Kind of I		,	
d 21	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, the M	e Cor	8 17. Father's Name (First, Middle, Lasi)	/	Foreman	18. Mother's Nam	ne (First, Middle		s Com	pany	
/lan	2 should be f and Mental H Is marked of aumatic eva	To Be	William H. Mix,	Sr.				a McCra		,		
Mary	id 2 sho Ith and I 27 Is me traume		19a. Informant's Name/Relationship				and Number or Ru				Code)	
re, I	s 1 and f Healt itam 2 other		William Mix, II 20a. Method of Disposition		20b. Place of Disp	06 Del h		Bel Air Date	MD. 20c. Location		own, State	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 Is marke any injury or other traumatic. once.		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	5)		matory or other pla ark Cemet	-	08-05		timor	e, MD	
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Lice	nsee			ess of Facility Funeral Ho Shur Spri				21227	
68760, 🛠	law requires that the death certificate be executed by the attending physician and carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid be detached for use as the burial-transit carbonid burial-transit carb	dicai Examiner	Medical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a to (or as b to (or as c	consequence of):	piratos Hea e Chra	cy to	aluve estru	irest, Ve ctive Disea	se	Approximate Interval Between Onset and Death
.O. Box	it the death certif by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of delive	ery Day Year	
rds, P	w requires that been signed b should be deta	ρχ	Part II. Other significant conditions	contributing to death b	ut not resulting in the c	nderlying cause giv	ven in Part I.		tobacco use cor Yes 2 □ No	_	ne cause of death?	
Vital Records,	The ate his page	Completed	/		/			24a. Was auto perfo 1 - Yes		prior to co death?	psy findings available mpletion of cause of	
Division of Vital	Attanding Physician: Trideath. Trideath. actor: Atter this certification by the funeral director, pa	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			f 28c. Injur Wor M 1	4 Nursing Ho	ome 5 Resi 28d. Describe	dence 6 Oti	rred	y) il Route Number,	
Div	spital or ours afte laral Diri	al Certii	4 ☐ Homicide determined	building, etc	of my knowledge, deat		no, data and place	City or To	wn, State)			
	To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical Example)	niner: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)	
	on with	2	29b. Signature and title of certifier	mulV	MQ	29c. Licens	DISI	83	Sep le	mbe	Day, Year) V 4, 200	
	Sta		30. Name and address of person who 31. Date filed (Month, Day, Year)	1. 42	eat Hern 23a) (Type, ar's Signature	Print) &	Law S	tree	Hary	berg	cen bo)	
DH	Registr	ar	SEP 0 6 200		& Apo	de			/			

MIXAR William H.

State of Maryland / Department of Health and Mental Hygien 2005

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				1 - For State Registrar	Otate of Wil	ai y tai i	Ce	rtificate of	Death	Wichtai II	Reg. No.	0.5	20002
		7 1	4	1. Decedent's Name (First, Middle, La	ast)	-				2. Date of I		Year	3. Time of Death
		Physici /Media		DOROTHY DOWNING M	1TCHELL					AUGUST			12:30 PM
		Examir		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, o	r Location of Deal	h	4c. Coun	ty of Death	
	* .			800 B. WINDSTREAM				EDGEWOO			HARFO		
	и	Funeral		,	Sex 7. Ag 1∰ M 2⋤ F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month,	Day, Year)		place (State or Foreign ntry)
	Ä.	Director		215-68-7419 Usual Residence of Decedent	Α	48				Sept.	25 , 1956	MAF	RYLAND
		yland		10a. State 10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
		Mar B-f st	tor	MD HARFORI			EDGEWO	OOD					1∐Yes 2∏No
		ith the Marylar or 28e-f show	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	What Cou	ntry?
		death with the Maryland ms 23s or 28e-f show Livest be millious		800 B. WINDSTREAM	1 WAY			21040			U.S.A	Α.	
		tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or I to Rican, etc.)	No- 14. Ra	ace - Ameri ack, White,	
	36	s afte	by Fi	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 ! If Yes, Give Year or Dates:	Vo		1 ☐ Yes 2X No	Specify:		Spec	ify:	
	8	ture		15. Decedent's E			16a. Dece	dent's Usual Occup	pation		16b. Kind of	BLA Business/In	
	215	n "ne	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)		(Give life.	kind of work done DO NOT use retired	during most of wo d)	rking	Too. rand of	D03111033/111	dustry
	212	d with giene or the	mo	12th	College (1-4or 5)+)	PAYRO	LL CLERK			BUSINE	ESS	
	pu	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23s or 28e-f show then Trainer in the market other treumetic event, If a Modical Examiliaring at	Be	17. Father's Name (First, Middle, Las	')				18. Mother's Na	me (First, Midd	le, Maiden Suma	me)	
	<u>yla</u>	Ment Ment arkec		WILLIAM A. DOWNING	3				NELLIE	B. DOW	NING		
	Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or Ri	u <i>ral R</i> oute Num	nber, City or Town	n, State, Zip	Code)
	6)	l and fealth im 27 her ti		TRACY DOWNING/SIS	STER	20h B		PARK AVE.			-	- 1: m	
	Ö	: Page tment o tent: If jury or		20a. Method of Disposition 1 🔀 Burial 2 🗀 Cremation 3		1		osition (Name of matory or other place	ce)	Date	20c. Location	- City or Fo	own, State
	Baltimore,			*4 □ Donation 5 □ Other (Special Sign of Funeral Service Life	-	Clar.		pel Cem.		-2005	Harford		
	Ba	Departing Important Indiana		21. Significate of Funeral Service Lice	nse								F/H-Harfor
		certificate be executed / Medical Examiner / Medical ransit / Medical rans	-	23a. Part1. Enter the disease, or con	aplications that caused	the death						eraee	en, MD 21001
				Immediate Cause (Final	one cause on each li	10.							Approximate Interval Between Onset and Death
				disease or condition resulting in death)	aMETA Due to (or as			NON SI	MALL I	una	CANER		amonths
					h BRI	211 -514		ETASTI	481c			100	troonths
-			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		ence of):		Tara				CI WOLITING
30	K		Examiner	that initiated events	C								
72	50,	oe exe sian a urial-		resulting in death) Last	Due to (or as	a consequ	ence of);						
Mitchell	68760,	cate b	Medical		d					_			
~	9 ×	ding l		IF FEMALE:	23c. If yes, outcome	of pregnar	nev				00.1.5		
2	Вох	atter for t	Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[Ectopic pregnancy Other (specify)	′			ate of delive onth	ery Day Year
-	0	0 0 0	iysi	1 Yes 2 No 9 Unknown	9□ Unknown								
ownin		ires that the signed by th d be detache	by Pi	Part II. Other significant conditions	contributing to death b	ut not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Dio	f tobacco use cor	tribute to th	ne cause of death?
2	rds	v requires been sign should be		HIU INFEC	TION					1 🛱	¥Yes 2□No	3 ☐ Prob	ably 4 Unknown
6	ecord	≥ A 75	Completed							24a. Wa		Were auto	psy findings available
5	H	ilcien: The lav certilicate has rector, page 2	m o							per	opsy formed? 2 X No	death?	mpletion of cause of
オ		ien: rtifica ctor, p	Bec	25. Was case referred to medical					26. Place of Dea				Cyanto
9	of V	Physicien: this certific ral director,	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 🗆 £	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	lome 5 Res	sidence 6 🗆 Ot	her (Specifi	<i>(</i>)
) So		ng Viter une	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui	y Year)	28b. Time o Injury	f 28c, Injun Wor	y at k?		how injury occu		
	sio	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No				
	Division	or Atten Ifter deat Director: in by the	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At hor c. (Specify	me, farm, sti)	reet, factory, office			(Street and Num own, State)	ber or Rura	I Route Number,
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		To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medical Example)	miner: On the basis of and manner sta	examinat	ion and/or in	vestigation, in my o	pinion, death occu	irred at the time	e, date and place	anner as st , and due to	the cause(s)
		Fo th within Fo th	Me	29b. Signature and title of certifier	•			29c. Licens			29d. Date sign		
		2 - 0		S. Seus	naelai	~	M.D	104	5530	S	09-	02.	2005
		di		30. Name and address of person who	completed cause of d	eath (Item	23а) (Туре,	Print) 602		2.5	D = -		1014
		1,		a. SIUHSALLA	m, 2017	to	200,	SATWO	OD RO	AD,	SELAIII	22	1014
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		registi	en .	OLI U h ZUU	3 10 00 100	, K	Alone.	100					

217-20-9147 Decided	
Social Security Number 6.5 sex 7. Age (fit yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 12, 1926 10a. State 10b. County 10c. City, Town or Location Severn 10d. Zip Code 10g. Citizen of W. May 12, 1926 10a. State 10b. County 10c. City, Town or Location Severn 10d. Zip Code 10g. Citizen of W. May 12, 1926 10a. State 10b. County 10c. City, Town or Location Severn 10d. Zip Code 10g. Citizen of W. USA 11. Marital Status 1 Never Married Married 11. Marital Status 1 Never Married Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 11. Marital Status 1 Never Married 12. Mas Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race Black 12. Married 12. Married 13. Married Never 14. Race Black 12. Married 15. Married 15. Married 16. Kind of Bus 16. Kind of Bus 16. Married	Arundel D. Birthplace (State or Fores
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24a. Was an autopsy performed? 1 Yes 2 No 3 25. Was case referred to medical examiner? 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2	
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autopsy performed?/ 1	☐ Probably 4 ☑ Unknov
25. Was case referred to medical examiner? 1 Yes 2 No	re autopsy findings availab or to completion of cause o
La Transfer Carrotte	dh?
La Transfer Carrotte	ith?]Yes 22No
1 Natural 5 Pending (Month, Day Year) Injury Work?	Yes 212/No
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	Yes 2 No (Specify)
building, etc. (Specify) City or Town, State)	Yes 2 No (Specify)
	Yes 2 No
29a. Certifier 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man	Yes 2 No
29a. Certifier 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man countries and manner stated. 29c. License number 29d. Date signed	Yes 2 No (Specify) or Rural Route Number, er as stated.
	(Specify) or Rural Route Number, er as stated. d due to the cause(s)
1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(Specify) or Rural Route Number, er as stated. d due to the cause(s) Month, Day, Year)
30. Name and Iddress of person who completed cause of death (Item 23a) (Type, Print) ONABAD 301 HOSPIFAL DAVE GLEN BUSINE MD 210	(Specify) or Rural Route Number, er as stated. d due to the cause(s)

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death **Physician** Month Day Year 50 PM ICKEI 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ISACTIMORE HUSPITAL If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 83 Yrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Months 1 M 200 Yrs. 2/18/22 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore City Director 1√DYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Hull Street 21230 usa Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: à white ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dominic Sergi 2 Annunziata Parisi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy A. Ochrzcin / Daughter 1341 Hull Street, Baltimore MD 21230 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State St Stanislaus Cemetery 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 09/21/2005 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr22. Name and Address of Facility Charles L. Stevens Funeral Home, 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final TABOUSM TULMONAR disease or condition resulting in death) Sequentially list conditions, it arry, leading to infline undecause. Enter Underlying Cause (Disease or injury that include underlying Cause (Disease or injury) Due to for se's consequence off Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai

Priysician /Medical **Examiner**

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funeral

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After

hours after death.

within 24 hours a

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Certification:

Medical

the attending physicien

certificate be executed

Division of Vital Records, P.O. Box 68760

or Attending Physician:

Funeral

Director

28a-f show

or Items 23a or

'natural',

Hygiene.

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If them 27 is marked other the any injury or other traumatic event. The

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown by Completed

1 ☐ Yes

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify)

23d. Date of delivery Month

24a. Was an autopsy performed?

1 Yes

26. Place of Death (Check only one)

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier

2No

5 Pending

investigation 6 Could not be determined

29c. License number

29d, Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death? 2 □ No

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 thinknown

1 Yes

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) con USENM 000 0

301

State Registrar 31. Date filed (Month, Day, Year) 2005

32. Registrar's Signature

	an cal		ANDREW RYAN	NEST				ER ^{ay} 1, 200	
Examir	ner	4a. Facility Name (If not institution, give GREATER BALTIMORE		TTED	4b. City, Town,	or Location of Dea	th	4c. County of Dea	
Funeral Director		5. Social Security Number 6. Se		yrs. last birthday		r tf Under 24 Hr		9. Bi (ear) 9. Bi 005 M	RE CO inhplace (State or Fore Country) ARYLAND
within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-1 ehow ha Medical Examinar must be notified at	tor	10a. State 10b. County MD. BALTI		. City, Town or I	LUTHERVI	LLE			10d. Inside City Lim 1 ☐ Yes 2 💢)
23a or 284	al Director	10e. Street and Number 811 MORRIS AV	'ENUE		10f. Zip Code	1093	10g	Citizen of What C	•
it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 ehov or other traumatic event, tra Medical Examinar must be notified at	by Funeral	11. Maritat Status XX Never Married 2	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XXNo If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Origin? (; ban, Mexican, Puel o <i>Specify</i> :	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
giene. r than "natu Ira Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Dec (Giv life.	edent's Usuat Occi e kind of work don DO NOT use retir	upation e during most of wo red)	prking 16	b. Kind of Business	s/Industry
t of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, Ine Mi	To Be C	17. Father's Name (First, Middle, Last)		STOR		TERE		OKOS	
lealth and m 27 is my her traum		19a. Informant's Name/Relationship (T DALE B. NESTOR (FATHER)	811	MORRIS A		ural Route Number, C THERVILLE,		
Department of Health Importent: If Item 27 any Injury or other to once.	Lia	20a. Method of Disposition XXX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License)	Removal from State	Cemetery, cre ILANEY V	position (Name of amatory or other place) ALLEY M. (22. Name and Addi	G. 09-0		MONIUM, MA	ARYLAND
Depa impo any i		P. W. Ruth	(R.G.R				L HOME, INC	1050 Y	ORK ROAD ,MD.21204
Abouts after data the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	cal Examiner			conucers -41.	-	me			
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	1 - For State of Maryland /	Department of Health and Certificate of Death	Mental Hygiene 2005 2888							
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death							
/Medical	Editulid Francis J. O Br.		August 31, 2005 10:45 P ^M							
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death								
Europa	Potomac Valley Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last I	Rockville birthday) If Under 1 Year If Under 24 Hrs.	Montgomery 8. Date of Birth 9. Birthplace (State or Foreign							
Funeral Director	181-20-0162 ¹ MM ² □F 77	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) July 7, 1928 Pennsylvania							
p >	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location								
shov			10d. Inside City Limits 1 ☐ Yes 2 ☑ No							
28a-i	10e. Street and Number	denton 10f. Zip Code	10g. Citizen of What Country?							
3a or	1306 Darwin Street	United States								
tter death with the Ma tterns 23a or 28a-1 s illustrast be notified	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert								
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in 72	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 	king 16b. Kind of Business/Industry							
ed within 72 ho ygiene. ner than "natur. it, it a Moles.	Elementary/Secondary (0-12) College (1-4or 5+)	dvertising Sales Mana	ger Railway Publication							
be filed within 72 hours atter death with the Maryland hal Hygiene. d other than "natural", or tiems 23a or 28a-1 show event, if a Marical Exc. ulnutr, ust be notified at the Commissed by Funeral Director.	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maiden Sumame)							
Ment Ment Ment Ment Ment Ment Ment Ment	Edmund O'Brien	_	tzpatrick							
VICAL 12 sh h and 7 is m traum			ral Route Number, City or Town, State, Zip Code)							
T and 1 and Health	20a. Method of Disposition 20b. Place	of Disposition (Name of	enton, Maryland 21113 Date 20c. Location - City or Town, State							
ages ant of y or o	St. P	tery, crematory or other place) Sept	. 3, Wantington Nov. Vowle							
perillicies, Mal yialiu ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examination at 200.	21. Signature of Funeral Service Licensee	netery 200 22. Name and Address of Facility	Dathard Cl.							
g age ag	M00198	7557 Wisconsin Ave	Funeral Home/ Chase, Inc. Bethesda, MD 20814-3501							
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
Pnysician	Immediate Cause (Final disease or condition Sudden Cardia	ac Death	Onset and Death 1 hour							
/Medical Examiner	resulting in death) Due to (or as a consequence)									
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The law requires that the death certificate has been signed by the attending page 2 should be detached for use a completed by Physician/Me.	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
Aduire and sign and build b	Dementia		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown							
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th. Afte	1 🛣 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	. Time of lnjury at Work? M 1 □ Yes 2 □ No								
tal or Attending P s atter death. al Director: Atter ted in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
ital or ral District	building, old. (openly)		ony or roun, dialoy							
the Hospi in 24 hou the Funer pletely fill edical	29a. Certifier (Check only (ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica completely filled in by the tuneral director, in Medical Certification: To Be C	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
+ 3 + ŏ	1 Amend well	D38262	September 1, 2005							
145	30. Name and address of person who completed cause of death (Item 23a	ı) (Type, Print)								
51		esearch Blvd.#330, Ro	ckville, Maryland 20850-3215							
State Registrar	31. Date filed (Month, Day, Year) SEP 0 C 211113	had s								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 28888 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept 5, 2005 Physician Margaret Patrick 2:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 ☐ M 2 😿 F 187-20-6548 82 PA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle Items 23a or 28a-f ehor Iner n'ust be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7548 Old Telegraph Rd 21076 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. other traumatic event, the Medical Examinar Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 0 1 ☐ Yes 2 ☐ No Specify: 3X Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within h and Mental Hygiene. 7 ts marked other than Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a t: If item 27 is Patricia Ann Patrick /Daughter 105 Vista Ave, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State Department of important: If any injury or St. Mark's Cemetery 9-9-05 Kennedy Township, PA 4 □ Donation 5 □ Other (Specify) 21. Signification of Sales Liver Kelly Gregory Fi Fink Funeral Home, P.A. 426 Crain Hwy, SW, Glen Burnie, MD 21061 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part1. Enter the disea shock, or heart failure. Approximate
Interval Between
Onset and Death
HOURS Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL **Physician** INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760,000 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, CEREBROVASCULAR Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2X ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident filled in by the 6 □Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 031136 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD., BACTIMORE, MD 21236 WALLACE, MD. 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200528889 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3, 2005 6:00 AM M Herman Powell September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Manor Care Rossville Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months Days Hours Min Yrs. 91 Director wv 232-16-0064 02/22/1914 Usual Residence of Decedent 0 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a 21236 4219 Darleigh Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□Yes 2MNo Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. State Highway Elementary/Secondary (0-12) College (1-4or 5+) Painter 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 and 2 should be fi of Health and Mental H litem 27 is marked of Charlie Lee Powell Bessie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oris Powell /SOn 4219 Darleigh Road Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sep 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives T101443 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Demonto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Grall Pto that initiated events resulting in death) Last Due to (or as a consequence of) Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Minal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 3 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Anatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide within 24 hours after de To the Funerel Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31464

Registrar

DHMH 17 Rev 1/2001

State

N.

Entand St Finte 30 & Baltinose MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

HASHMI.

SEP 0 6 2005

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31. Date filed (Month, Day, Year)

			1 - State Registrar	ate of Maryland / Depa	artment of H	lealth and M Death	lental Hygie		28890				
	Physici /Medic		Decedent's Name (First, Middle, Last)	Gloria B. Peaker			2. Date of Death Month 8 28	Day Year	3. Time of Death 10:00 a.M				
).	Examin		4a. Facility Name (If not institution, give street 940 Brooks Lane	and number)	4b. City, Town, or Balto	r Location of Death		4c. County of Death N/A	ı				
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay 4-27-19	9. Birth	nplace (State or Foreign untry) Md				
	e Maryland 3e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md 1	N/A Balto	ocation				10d. Inside City Limits 1 Yes 2 No				
	h with th	al Dire	10e. Street and Number 940 Brooks Lane 10f. Zip Code 21217					Citizen of What Co	•				
036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depriment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28s-f show any injury or other treumetic event. Its Modical Examinational percelling at OREs.	by Funeral Director	A	CV CCN-	Was Decedent of H If Yes, specify Cuba 1 Yes No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:Blace	e, etc.				
21215-0036	d within 72 ho piene. r then netur	ompleted	ompleted	ompleted	ompleted	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) 12th grade	npleted) 16a. Dece (Give infe.) 16a. Dece (Give life.) 16a. Dece (Give life.) 16a. Dece	dent's Usual Occupi B kind of work done of DO NOT use retired Homemak	during most of work d)	ing 16b	. Kind of Business/I	ndustry
Maryland 2	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Ellis Day	M/ A			e (First, Middle, Maid Matthews	den Sumame)					
	alth and National Nat		19a. Informant's Name/Relationship (Type, F Harry X. Peaker - Hu		ing Address (Street a		al Route Number, Ci		ïp Code)				
Baltimore,	Pages 1 a tent of He nt: If item iry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	Val HOIII State	osition (Name of matory or other place hedral Ce		1	Location - City or 1	rown, State				
Balti	permit. Dep rtm Importe any inju		21. Signature of Funeral Service Licensee		2. Name and Addres	ss of Facility Ma	rch F/H W sh Avenue	est	Id 21215				
	Fnysician /Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not en use on each line.	ter the mode of dyin	nfaut	16,7		Approximate Interval Between Onset and Death				
8760,	cate be executed by strian and the burial-transit	dical Examiner		Sequentially list conditions, fary, Lador g of innediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of):	eioth /	react c	lesla	Q	years			
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Division	e Hospitel or Attend 24 hours after death 8 Funerel Director: etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: (n: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.	th occurred at the tin exestigation, in my of	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	OB	29c. License	2488	? 29d.	Date signed (Month	Day, Year)				
200	8		30. Name and address of person who completed the state of	2-(11) 2-22	W. Colde	piny la	ne, Bal	truve	MO 2210				
*	Sta Registr		31. Date filed (Month, Say Year) 6 200	32. Redistrar's Signature	perter	,							

State of Maryland / Department of Health and Mental Hygiene 2005 28891 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18 Lillie Mae Pinder /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death, 4c. County of Death **Examiner** GRARRAL SMURL N/A If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Shourity Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2√□ F Director 219-12-7239 Dec 18, 1924 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28e-f show the Medical Examinations that he notified at **Baltimore** 1 Yes 2 □ No Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 342 Bloom Street 21217 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Black 3 3 X Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hospital Supervisor Central Supply 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil ment of Health and Mental H lent: If item 27 Is marked ott Florence Madden William Mitchell treumatic 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 Glen Avenue Baltimore, Maryland 21217 Wilhelmenia Johnson Daughter or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 09/08/05 Owings Mills, Md. 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery Funeral Service License 21. Sign! 22. Name and Address of Facility Estep Brothers Funeral Service 1300 Eutaw Place, Baltimore, Md. 21217 23a. Part1. Enter the disease, or complications that cause of shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 🗆 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 PNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director; 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type-Maryland ratelye va State Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 28892 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FRANKLIN PORTER Aubrusi 30, doc4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL GOOD SAMARITAN BALTIMORE NA If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 04.28 · 194 Birthplace (State or Foreign Country) 1**⊠** M 2□ F 216.36.4675 Yrs Director MD Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h Cough 10d. Inside City Limits itam 27 la marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Newfical Evantinar must be notified at Director MD BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1928 HEATHFIELD ROAD 21239 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked othar than "natural", or Ital Black, White, etc. 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ð Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MASON CONSTRUCTION 121H GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SIMON PORTER PAULINE JORDAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Ia n any injury or other traum ALICE PORTER (WIFE 1928 HEATHFIELD RD., BALTO, MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS 09.03.05 MIDDLE RIVER , MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licen auc 5151 BALTO. NATU PIKE, BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASEVD unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the detached Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DIABETES MELLITUS Completed 1 Yes 2 No 3 Probably 4 Driknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No of Vital 2 25. Was case referred to medical 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Yes 2□No 1 Inpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Y, ar) 28b. Time of Certification: 28d. Describe how injury occurred After Division To the Hospital or Attanding 5 Pending Injury 1. Natural 28e. Place of Inj. ry - At home, farm, street, factory, office building, etc. (Specify) death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: in by the 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Momicide a Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0018230 August 30 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDAMPAN MD21239 GOOD SAMBRITAN HOSPITAL KALATHIL 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 2, **Physician** HARRIET PORCELAIN 2005 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Nonths Days Hours Min. 8. Date of Birth 11/23/1929 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 106-12-5723 75 Yrs. Director N.Y. Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director MD N/A 1 ¥ Yes 2 □ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 FALLSTAFF ROAD APT. #38 21209 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "na eny injury or other treumatic event, It a Mustic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **ABRAHAM** BAUM ျှ ROSE BURD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 FALLSTAFF ROAD APT. #38-BALTIMORE, MD 21209 CECIL PORCELAIN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT. HEBRON CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 09/04/2005 | FLUSHING, N.Y. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respect on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit rkinson Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ NO the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Jas autopsy performed? 2 100 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Matural s after do. 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 29a. Certifier 1 🕒 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fun completely 1 (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 9/2/05 H31615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Are Poltrione. Maryland Walks 00 15 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 6 2005 Registrar

JC 05-05870 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carla Lavine Quinones State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a&27 per me G847 et illeate of Beath Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** arla Lavine Quinones August 31 2005 11:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 727 Druid Park Lake Drive Apt. 11 G Baltimore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 X F 36 215.86.9511 30.1969 Director MD Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural", or items 23a or 28e-f ehovenly injury or other traumatic event, the Medical Examinat must be notified at once. Baltimore MD 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 727 Druid Park Lake Drive #116 21217 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Environmental Technician 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kou Alice Mainor Lockley 19a. Immant's Name/Relati hip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 Park Heights Ave. Balto MD 21215 Alice Jackson / Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09.06.05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION 21. Signature of Funeral Service License Vaughn C. Greene Funeral services SISINGALTIMORE National Pile Balto. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Hypertensive Atherosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Scuantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Furneral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burish-transit completely filled in by the furneral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ es 2 ☐ No 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ROther (Specify) Scene 1 X Yes 2 ☐ No 27. Manner of Death Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) September 01, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUB10 , MD ANA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien200528895 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles Ohn 9:45 PM ROBINSON 05 /Medical 4a. Fedility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Medical COM CON Battimore MD 21201 Baltimore VA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**%** M 2□ F 15 Yrs. 248115 Director 215 10/22/1929 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City. Town or Location in than "natural", or Items 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5015 Briarclift Road 21229 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1948-52 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify by Specify: 3 ☐ Widowed 4 🎖 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Horse Racing 12 Assistant Trainer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked off jury or other traumatic even Be ၉ Charles Edward Robinson Edith Marie Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Robert Arthur Road Westminster, MD 21158 Paul M. Robinson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of I Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory. Inc. 09/06/05 Baltimore, MD 21. Signatur Funeral Service Ocensee ²² Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Edward A Gregorchik

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a. Reval failure disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner INTUCTION Mucardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Die to (or as a consequence of): Examine burial-transit or Attending Physician: The law requires that the death certificate be executed days that initiated events resulting in death) Last D to (or as a consequence of): Box 68760. inding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Atual fibrillation, Diabetes Mellitus 2 No 3 Probably 4 □Unknown heart disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 XNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X npatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Amy Stump MD 516781 September 2,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. greene St Department of Sugery, Univ. Nauyland Medial Certer, Battimore MD 21201 32. Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28896 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day :00 AM Olga Jacoba Medary -05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 35 Hampton 5. Social Security Number 6. Road Arundel inthic 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthptace (State or Foreign Country) Months Days Min. 1 ☐ M 2 🕱 F Hours Pennsylvania

Funeral Director with the Maryland other treumetic event, the Medical Examiner must be notified at ŏ or Items 23e death filed within 72 hours after Baltimore, Maryland 21215-0036 "naturel", Hygiene.

Physician

/Medical

Examiner

Directo

Funeral

δ

Completed

is marked other then permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth eny jury or other treumetic event 2008.

Physician /Medical Examiner

Examine attending physician and for use as the burial-transit Physiclan/Medical

Box 68760

Division of Vital Records, P.O.

The law requires that the death certificate be executed ed by the a signed b page 2 s certificate To the Hospitel or Attending Physicien: director this After thi funeral

within 24 hours after deam.
To the Funerel Director: Af

þ Completed Be 2 Certification: Medical

7 / Yrs. 16, 201-28-0555 Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Shore Acres Road 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Bennett Medary, III Rhoda Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Hampton Road Catherine Lindner/Daughter Linthicum, MD 21090 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 9/3/05 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee Edward A. Gregorchik MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to r as a consequence of): Foylure Artery Disease Sequentially list conditions, if ny land limm cause. Enter Underlying Cause (Disease or injury eronary Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

investigation

6 Could not be determined

5 Pending

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy performed?

28d. Describe how injury occurred

1 🗆 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

1 □ Yes 2 XNo

Approximate Interval Between Onset and Death

Year

Daughter's

residence

30. Name and address of person who com (let d cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

2002 Medical Parkung SZ-310 31. Date filed (Month, Day, Year) MD 32. Begistrar's Signature

State SEP 0 6 2005 Registrai

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

2 ☐ Accident

3 Suicide

4 - Homicide

1 Inpatient 2 ER/Outpatient 3 DOA

Place of tnitury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 28897 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Robinson-Jones Elizabeth 3333 LM /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Days Hours Director 558-86-2470 52 12 05 CÁ Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location Item 27 ie marked other then "natural", or items 23a or 28e-f show other treumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD Baltimore NA the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 820 Argonne Drive Apt H U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify δ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if Item 27 ie marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12th grade Home na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Franks ဂ္ Bobbie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: if Item 27 le Michael Jones-Son 1014 Mcaleer Ct., Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 Burial Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc.9/3/05 Baltimore, Md 21. Signal re If Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, any 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSIS Physician Se /Medical Due to (of as a consequence of): Examiner Abcess Smin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? page 1 ☐ Yes 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the within 24 hours after deat To the Funerel Director; 6 Could not be determined 3 Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical o the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) U0053539 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 2018. University Parking Mi 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 28898 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:46 PM Mary Royster 29 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AGNES HUSPITAL BALTIMORE **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2√□ F 217-30-4082 Feb 20, 1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3148 Leeds Street U.S.A. 21229 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 👿 No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel E. Butcher Mary J. Butcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Butcher 3148 Leeds Street Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Md 09/03/05 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 21. Sign, up of Funeral Service Licence 22. Name and Address of Facility Estep Brothers Funeral Service, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PNEUMONIA

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Be

10a, State

Funeral

Director

of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, if a Medical Exacts are must be notified.

permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Menial Hygiene. Important: If fem 27 is marked other than "natural", or iteme 23a any injury or other traumatic event, II a Medical Examples once.

Baltimore, Maryland 21215-0036

with the Maryland

Physician/Medical Exami Medical Certification: To Be Completed by certificate has

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, : After this certifical funeral director, neral Director: A filled in by the fu within 24 hours after To the Funeral Dire

	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SEPTIC SHOCK Due to (or as a consequence of): C. SQUAMOUS CEL	L LUNG CAR	CINOMA	HOURS MONTHS
1	Cooking in Codiny East	Due to (or as a consequence of): d.			
.)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		opic pregnancy ner (specify)	23d. Date of Month	
	Part II. Other significant conditions of	contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco use contribu	ite to the cause of death?
				performed? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
2	1 ☐ Yes 2 No	Hospital: 1 Impatient 2 ER/Outpatient 3	B DOA Other: 4 Nursing Hom	e 5 Residence 6 Other	(Specify)
	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	· }		8d. Describe how injury occurred	
	3 Suicide 6 Could not b 4 Homicide determined		factory, office 2	8f. Location (Street and Number of City or Town, State)	or Rural Route Number,
	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place, as gation, in my opinion, death occurred	nd due to the cause(s) and manned at the time, date and place, and	er as stated. due to the cause(s)
	29b. Signature and title of certifier	1	29c. License number	29d. Date signed (A	Nonth, Day, Year)
	I dange Uni	utwomics, MD	P 17602	AUGUST,	29th 2005

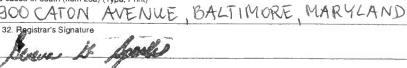
Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LARYSA KNINTKIENICZ, 900 CATON



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 205 For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Kudy 12:48 PM Kichard September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death and a Stown

And a Stown

Inder 1 Year If Under 24 Hrs. 8. Date of Birth

Tiths Days Hours Min. (Month Day,

Perfember 2, Examiner Baltimore Hospita enter 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F 1938 374-38-0111 67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Capartment of Health and Mental Hygiene. In portant: If item 271a marked other than "natural", or Items 23a or 28a-f show ary injury or other traumatic event, Item Medical Eradii in must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Maryland Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9840 Branchleigh Road 21133 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Caucasian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Department of 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States College (1-4or 5+) Elementary/Secondary (0-12) Federal Auditor Transportation Goverment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Rudy, Sr. Anna Walchko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 9840 Branchleigh Road Randallstown, MD 21133 Mrs. Pauline Rudy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State St. Florian Cemetery 09-08-2005 Unity, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee 8728 Liberty Rd. Randallstown, MD 21133-4784 Kollner M00333 23a. Paid. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multiple organ

Due to (or as a consequence of): system 24 hours disease or condition resulting in death) /Medical **Examiner** stemic inflammatory response Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit immune system and Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical Metastatic prostate 4 years IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year detached for in the past 12 months? 5 Cher (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. failure 2 1 No 3 Probably 4 Unknown Hypertension 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Valvular cardiomyopath 24a. Was an autopsy performed? Yes 2 No Hemorrhagic 1 ☐ Yes STITIS To the Hospital or Attending Phyaician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case refer d medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manger of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28462 September 4, 2005 10 30. Nam address of person who completed cause of death (Item 23a) (Type, Print) Hospital Center Randallstown, Maryland Northwest 13051 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 6 2005 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 28900 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ANNE ROSEMAN 9:40 A M september /Medical 1,2005 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | S. Date of Birth MAY 15, 1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 ⋤ F Director 212-22-3071 79 Yrs. Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location item 27 is marked other then "natural", or items 23s or 28e-1 show other treumatic event, the Medical Evantrar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4508 TAPSCOTT ROAD 21208 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc. 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.
Is marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL WORKER U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM GOLDMAN SADIE LUBARSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 ia JOSHUA ROSEMAN / HUSBAND 4508 TAPSCOTT ROAD BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) SOCIETY Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ites
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI BENEVOLENT 109/04/2005 ROSEDALE, MD 21. Signature of Fundal Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. lan4 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Systemic Inflymmatory Response Syndrome disease or condition resulting in death) 48 hoves /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. the a 9□ Unknown 9 ☐ Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by stenosii + mitrul 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?, Yes 27 No Sustemic lactic acidosis Division of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. ■ Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Both Home MO Critical Care Physician MD D41593 September 1, 2005 30. Name and a 47 ss of person who completed cause of death (Item 23a) (Type, Print) Peter J. Sloane. mp 3333 N. Calvert 57 #650, Baltimore, mp 21218 31. Date filed (Month, Day, Year) 32/Registrar's Signature Registrar SEP 0 6 2005

State of Maryland / Department of Health and Mental Hygien 2005 28901 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** TENNYSON SAUNIDERS 07:45 PM 31 August /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lospital Baltimore Agnes If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 12 M 2□ F 212-58-574 Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28...*- any injury or other traumatic event, the Mental Marians and Diffe. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director CALTIMORE 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11.5.A. 1106 LYNDHURST STREET Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BIACK Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAUNIDERS 38. LESLIE BERDELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE SAUNDERS JR. BROTHER 3610 COPLEY RD, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 09-06-2005 BALTIMORE, MARY LAND CEDAR HILL CEM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** Septic disease or condition resulting in death) One day /Medical Due to (or as a consequence of): Examiner Aspiration Pl Due to (or as a consequence of) Preumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Anoxic Brain

Due to (or as a consequence of): this certificate has been signed by the ettending physician and ral director, page 2 should be detached for use as the burial-trar Physician/Medical lure Heart Fai IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 3 ☐ Probably 4 ☑Unknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? 1 ☐ Yes 2XNo Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 within 24 hours a To the Funeral C completely filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A52438528 lenbere Bahru, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhu, St Agnel topial good to Ivenue, 31. Date filed (Month, Day, Year) 32. Figurar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20051 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 37 SCHUYLER **RUGUST** 0 2005 MULLINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Baltimore Il Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** 220-12 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Exertiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced "netural", ieted 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Compl Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mothe s Name (First, Middle, Maiden Surname, ages 1 and 2 should be not of Health and Menta: If item 27 is marked Saines Howard 19a. Informant's Name/Relationship (Type ess (Street and Number Number, City or Town, State, Zip Code) town, 000 21133 an other 1 20a. Method of Disposition 20b. Place of Dispositi Pages 1 Burial 2 Cremation 3 Removal from State permit. Page Department c Important: If any injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pandallstown, MO 21123 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UROSEPSIS /Medical Due to (or as a consequence of): Examiner HEUMMINIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician lan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Physic 1 ☐ Yes 2 No 9 ☐ Unknown Division of Vital Records, P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Tyes 1 Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 21 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3157 D0041410 August 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER TYLTH WEST HISPITAL CENTER RANDAUS TOWN MO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SEP 0 6 2005

32. Begistrar's Signature

State of Maryland / Department of Health and Mental Hygiene? 115

28903

			1 - State Registrar		Ce	rtificate of L	Death		Reg. No.	00	205	50
		3) (E	1. Decedent's Name (First, Middle	le, Last)				2. Date of De	eath Day	Year	3. Time of De	ath
	Physici /Medio		Francis	J. S	ullivan		Ş	SEPTEME			1:30A	М
	Examir		4a. Facility Name (If not institution			4b. City, Town, or			4c. County			
		Ш	Saint Joseph			If I Index 1 Year	Tows				more	
	Funeral Director		5. Social Security Number 294-09-5759 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bin (Month, Da Sept.	24,1914	Соді	place (State or Fontry) hio	oreign
	land ow		10a. State 10b. County	,	10c. City, Town or Lo	ocation					10d. Inside City L	imits
	Mary First	ţŏ	Maryland Balti	more	Timoniu	ım					1 Tes 2	X No
	n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cou	ntry?	
	23a o	ai D	12261 Roundwoo	d Road, Apt.	1507	2109	3		U.	S.A.		
	ems ems	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes or No	o- 14. Rac		can Indian,	
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, it a Medical Examination in cliffed at 2000.	d by Funeral	1 ☐ Never Married 2 💢 Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 X Yes 2 ☐ If Yes, Give 1 1 Year or Dates:	No	1 ☐ Yes 21 No	Specify:	,	Specify		White	
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2	Hygie Hygie ther i		17. Father's Name (First, Middle,	Last)	Marke	ting ASSU		ame (First, Middle			iiipariy	
Maryland	d be antal	o Be		llivan			Mary	Dola		,		
$\overline{\leq}$	Shoul nd Me mark	မ	19a. Informant's Name/Relations		19b. Mailii	ng Address (Street a				State, Ziu	Code) 2109	3
	nd 2 ulth a 27 ls		Betty Sulliva	n Wife		Roundwoo					Maryla	
re,	s 1 a of Hez item oths		20a. Method of Disposition		20b. Place of Dispo	osition (Name of		Date	20c. Location -			110
Baltimore,	Page nent c int: if		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		Dulaney	Valley al Garden	ຶ ∫9-3·	-2005	Timoniu	ım	Marylan	ıd
aĦ	permit. Departm Importe any inju		21. Signature of Funeral Service	Licensee		2. Name and Addres			Towson F			
Ω_	80 E # 8		Tous le	tagan		1050 York	Road		Marylan		1204	
H			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause t only one cause on each I	d the death. Do not entine.	ter the mode of dying	g, such as cardia	ac or respiratory a	rrest,		Approximate Interval Betwee	
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68760,	icate phys s the	/Medical		d								
P.O. Box (death of attention of for us	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				te of delive onth	ery Day Yea	r
	that the ded by detail	Ph.	Part II. Other significant conditi	ons contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use cont	ribute to t	he cause of deat	h?
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<u>=</u>	yeicie is cer direct	To B	examiner? 1 ☐ Yes 2 🕩 No	Hospital:	ent 2 ER/Outpatier	nt 3□ DOA Othe	ar.	Home 5 Resi		er (Specif	(v)	
Division of Vital	r Attending Physicien: ler death. irsctor: Affer this certilics by the tuneral director, i	L:u	27. Manner of Death	28a. Date of Inju	ury 28b. Time o				how injury occurr		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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	15+1		30. Name and address of person	who completed cause of	death (Item 23a) (Type,							
	12		BOON P.LIM M	.D. 7601 O	SLER DRIV	E JOWSOI	N_MARYL	AND 21	204			
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State of Maryland / Department of Health and Mental Hygiene?

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	Physici	an	Decedent's Name (First, Middle, Last	st)					2	2. Date of Deat	h Day th	Year	3. Time of Death
	/Media		FLORENCE SCH							EPTEMBER	06,3	1005	2.30 M
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	Funeral		Social Security Number 6. S		e (In yrs. last birthday			If Under	24 Hrs. 8	Date of Birth (Month Day,		9. Birtho	place (State or Foreign ntry) ennsylvanie
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215-0036	ours afterall, or It	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ło	1 ☐ Yes 2		Specify:	, 1 40110 111	oan, 610.)		ck, White, y: Whi	
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and	ರ್ಷ ವಿಶ್	To B	Charles E.	. Smith						Foose		,	
Mary	and 2 should be ealth and Mental n 27 is markad iar traumatic av	-	19a. Informant's Na Colidinach Karla S. Geldmack	r - Daugh	19b. Mail ter 49 Ca	ling Address	(Street a	nd Numbe	r or Rural F sters	Route Number,	City or Town,	State, Zip	Code)
ē,	1 a He th		20a. Method of Disposition		20b. Place of Disp	osition (Nam	e of		Dat	-	20c. Location		wn, State
Ē	Pages nent of I int: If its iry or o		1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State ')	Mt. Rose				ept.	9, 2009	York,	Pa.	
saltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Juneral Service Licen	2. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21117						177			
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused one cause on each lin	the death. Do not er e.	nter the mode	of dying	, such as o	cardiac or r	espiratory arre	st,		Approximate Interval Between
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cords	quire; an sig uld be									1 ☐ Yes	2 🗆 No	3 Proba	ably 47X Unknown
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> 5	Physician: r this certific ral director,	2	1 ☐ Yes 2 No		nt 2 ER/Outpatie		Othe	r. 4 🗆 Nur:	sing Home	5 🗌 Residen	ice 6 🗆 Oth	er (Specify,)
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2	al or Attand safter death I Diractor: / d in by the f	Certification:	4 Homicide determined	building, etc	ry - At home, farm, st . (Specify)	reet, ractory,	Office		201.	City or Town,	State)	er or Hurai	Route Number,
	To the Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of iner: On the basis of	examination and/or in	th occurred at	the time	e, date and inion, death	place, and	due to the cau	ise(s) and ma	nner as sta	ited.
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	⊢ 3 ⊢ 8		Dochillo						0			8.8	2005.
1	19	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 & NAME OF A PA											
			MALTHUREST HISPITAL CENTER RANGEMUSTALA								33		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	Arest	1		- Addition	-			
	Registra	ar	JET U C	2005	ELISA SI	1000							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 9 **Physician** Elliott Shannon 1 2005 9009a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1022 Upnor Road Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 N . C . **Funeral** Days Hours 240-30-6773 83 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Modical Examples of N/A Director Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Upnor Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify 3 XWidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry L. Pages 1 and 2 should be filed within thent of Health and Mental Hygiene. ant: If item 27 is marked other transvery or other transverse. Elementary/Secondary (0-12) College (1-4or 5+) 3rd Candy Maker Candy Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Teddy Shannon Marie ပ Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Boulware-daughter 1022 Upnor Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Removal from State Greenmount Crematory 9/8/05 Baltimore MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST I on 1101 E. North Avenue Balto., MD 000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE Heart Failure /Medical **Examiner** pulmonary hypertension 4 years Sequentially list conditions, I any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of The law requires that the death certificate be executed the burial-transit chronic obstructive lung disease 4 years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy detached for in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed binous 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy ormed? 2 ☐ No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 sesidence 6 Other (Specify) Hospital: ို 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and ittle of certifier 30. Name and address of person who completed cau Behedere Aug #22 State Registrar

			For State	State of Marylar		artment of F ctificate of			gien e∠ U Reg. No.	105	28906
		1	Registrar 1. Decedent's Name (First, Middle, Las	t)		timodio or	Douin	2. Date of Dea	ath		3. Time of Death
	Physici /Medio		CLARA D.	SLA	TER			Month	05 05	05	8:30 M
	Examin	er	4a. Fecility Name (If not institution, give				r Location of Deat	h		nty of Deeth	
		×	Franklin Woods Nur 5. Social Security Number 6. Se		last birthday)	Roseda	ITE If Under 24 Hrs	8 Date of Birt		altimo	
9	Funeral Director			□ M 20XF 88	Yrs.	Months Days	Hours Min.		1917	Penn	ace (Stete or Foreign try) Sylvania
	PL .		Usual Residence of Decedent	100							
	anyla shov	5	10a. State 10b. County Maryland Baltimo		ty, Town or Lo Essex					10	Od. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Directo	10e. Street and Number	ile	TP964	10f. Zip Code			10g. Citizen o	of What Coun	
	h with	io is	1729 Glen Curtis F	Rd.		2122	21		US.		,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f show ship injury or other traumatic event, the Medical Examiner is sail be crafilled at ODGE.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes 2X No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ace - America lack, White, e city: Whit	etc.
5-0	72 hc natur	eted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of	Business/Ind	ustry
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	filed within Hygiene. other than ant, the W	e Co	17. Father's Name (First, Middle, Last)		1		18. Mother's Nar	me (First, Middle,			
lan	should be t and Mental B marked of umatic eva	To B	Jacob Daugherty		1		Effie	M. Allem	nan		
Maryland	2 should have and have is managed		19a. fnformant's Name/Relationship (7				at and Number or Rural Route Number, City or Town, State, Zip Code)				
	and sealth		Edward Slater (Sor		1			_			0
Baltimore,	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify		och. 9/8/	2005	Joppa,	, Mary			
Balt	permit. Departrimports any inje		21. Signature of Funeral Service Licen	wzkousko-	ss of Facility Li Funera Lastern A	l Home P venue Es	A. sex, M	d. 212	21		
A135	Physician /Medical Examiner		23a. Par 1. Enter the disease, or complete ck, or heart failure. List only of firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a consect					Approximate Interval Between Onset and Death		
68760,	eath certificate be executed attending physician and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying that initiated events resulting in death) Last	C. Due to (or as a consect of the to consect of							
	ertifica ding ph		fF FEMALE:	23c. If yes, outcome of pregn.				-			
.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c 9 □ Unknown	el déath 3	Ectopic pregnancy Other (specify)	/			Date of deliver	ry Day Year
rds, P.	w requires that been signed t should be det	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.				e cause of death? ably 4 Unknown
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of Vital	Physician: The this certificate hiral director, page	Be	25. Was case referred to medical examiner?	Heavitali				ath (Check only o	ne)		
of	> 0 0	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 Inpatient 2 28a. Date of Injury	_		4 Muising r	dome 5 Resid)
	fee fee	tion	1 Anatural 5 Pending	(Month, Day Yeer)	28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe	10w injury occi	urrea	
Division	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str fy)		-	28f. Location (S City or Tox		nber or Rural	Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my known inner: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tire vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier	0	120	29c. Licens	se number	(29d. Date sign	ned (Month, L	Dey, Year)
ļ	n		30. Name and address of person who	completed cause of death (Iter			, • 0	- 0	- PICOVI	1101	- ~
) Sta	ite	Jom Edmont Son 31. Date filed (Month, Day, Year)	MD, 9105 Francisco	Klin Sy	ware Dr	ive Sk. 3	12, 180/	Smre	MD	2/23/
	Registi		CED O a some March								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2015 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Soon Ηſ Slezak 09 02 2005 11:4 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner AGNES HEALTH CARE BALTIMORF 9. Birthplace (State or Foreign Country) S. Korea 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1□M 2₹ F Yrs. 217-58-5173 66 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Funeral Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Woodbridge Road 21228 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify: Specify: Asian Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Retail iges 1 and 2 should be filed into the Hoalth and Mental Hygie If item 27 le marked other for other traumatic event, It other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bang Tae Jn Do Li Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9933 Springfield Drive, Ellicott City, No. 21042
lace of Disposition (Name of Date 20c. Location - City or Town, State <u>Soon Ja So</u> (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any njury or once. Lake View Memorial Pk | 09/07/05 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service License 8728 Liberty Road, Randallstown, Maryland 21133 ellner MOGJJ3 23a. Part I Effer the deas if r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aortic dissection Abdominal Physician HOUYS /Medical Examiner Hours Shock ardiogenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Maim 4 Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ carcinoma 1 Yes 2 No 3 Probably 4 Unknown namons cell Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 VInpatient 2 1 ✓ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how insury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18608 09-02-2005 30. Name and add ess of person of completed cause of death (Item 23a) (Type, Print) JANANNATHAN , 900 CATON AVE BALTIMORE - 21229 PRIYA 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

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Vital

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State of Maryland / Department of Health and Mental Hygien 2005

28908

			For State Registrar	State of Mary		ertificate of		Re	eg. No.	
			Decedent's Name (First, Middle, Last	t)				2. Date of Death		3. Time of Death
	Physicia /Medic	al	Anna Stephanie	e Seltzer				8	28 Vear	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th ~ /
				13,de	yrs. last birthda) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	### P	thplace (State or Foreign
	Funeral Director		217-52-3980	□M 257 F	33 Yrs.	Months Days	Hours Min.	(Month, Day, May 16,	Year) Co	echoslovakia
	and	- H	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
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	n the	Irec	10e. Street and Number		DOPPH	10f. Zip Code	-	11	0g. Citîzen of What C	ountry?
	th wit	alD	300 Belfast Cou			210			USA	
	tems	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No	rin U.S. 13	I. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4X Divorced	If Yes, Give Year or Dates:		1□ Yes 🎾 No	Specify:		Specify:	White
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "netural, or Items 23s or 28s-1 show other treumstic event, II a Modified Examinar must be notified at	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occup	pation during most of work		16b. Kind of Business	
215	within 7. ene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	d)	9		
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and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last,	Greipel			Hedwig	(nmn)	Kral	
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S	nd 2 shoulth and 27 is mu		Richard Seltzer /	Son	300	Belfast	Ct., Jopa	a, MD 21	085	
re,	ges 1 ar t of Hea if item or other		20a. Method of Disposition	IS		position (Name of rematory or other pla			20c. Location - City or	Town, State
m	Page nent o ant: If ary or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of the Co		Hilltop	Service	corp. 8-3		Towson, Ma	ryland
Baltimore,	permit, Page Department of Importent: If any injury of		21. Signature of Funeral Service Lice	6/		22. Name and Addre	ess of Facility Uneral Hor	me, P.A.		
Ш	20589		Jegles ()	Auch	death Do not	1317 Coke	sbury Road	d, Abing	don, Maryl	Approximate
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each line.				or respiratory and	031,	Interval Between Onset and Death
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	الجما	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	unsaquanca UI).					
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90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a co	onsequence or).					
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	nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy	0.05			23d. Date of de	elivery
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ord	w requir been s should	eted	Paulnta							
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alF			25. Was case referred to medical	<u> </u>			26 Place of Dea	1 ☐ Yes		s 2 No
<u>X</u>	ysician: is certific director,	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpa	tient 3 DOA	than .		ence 6 Other (Sp	ecify)
10	를 끌 등	I=	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injur		ury at ork?	28d. Describe h	ow injury occurred	
io	death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	n		M 1[]Yes 2□No			
Division of Vital Records,	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification:	3 Suicide 6 Could not l 4 Homicide determined		- At home, farm, 'Specify)	street, factory, office	•	28f. Location (S City or Town	itreet and Number or F m, State)	tural Houte Number,
	To the Hospital or Al within 24 hours after or To the Funerel Directompletely filled in by	I Ce	29a, Certifier f Certifying P	hysician: To the best of r	ny knowledge, d	eath occurred at the	time, date and place	, and due to the o	cause(s) and manner a	as stated.
	To the Hospital within 24 hours of To the Funeral completely filled	dica	(Check only 2 Medical Exa	miner: On the basis of ex and manner state	camination and/o	r investigation, in my	opinion, death occu	rred at the time, o	date and place, and du	ie to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	1 11		29c. Licer	nse number	2	29d. Date signed (Mor	nth, Day, Year)
	/		KA C	1 /Min	<u> </u>	()	27975		1/30/05	Ana,
	27		30. Name and address of person who	completed cause of deal	th (Item 23a) (Ty	pe, Print)	1.1 1.	00	Par Diell-	
-	7	725	31. Date filed (Month, Day, Year)	Chr on ge	Seignature	a flyndd	101/20	x /200/	maley	
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State of Maryland / Department of Health and Mental Hygien® 0.0 5

		1 - For State Registrar 1. Decement's Name (First, Middle, L.	State of Maryla	and / Depa	tificate of	Death		g. No.	3. Time of Death
	ician dical niner	Leve, V	ye street and gumber)	Conto	4b. City, Town, o	r Location of Death	9	4c. County of De	1215 A M
Funer Directo	_	113 10 1023	1 COM CAL	rs. last birthoay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, May 13,	1923 Te	irthplace (State or Foreign Country) PNNESSEE
he Maryland 8e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harfo		City, Town or Lo			1/	0g. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 🕍No
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ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygene. d other than "natural", or Itams 23a or 28e-f show event, the Modical Examinat must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	11	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
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d be antal	To Be Co	17. Father's Name (First, Middle, Las		Macili	IIISC	18. Mother's Nam			uracturer
re, Maryis s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Marie E. Scott			-			city or Town, State	
0 0		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 14 □ Donation 5 □ Other (Spec			sition (Name of natory or other place	10161	2005	Oc. Location - City o	
permit. Pag Department Important: any injury o	SUCE.	21. Signature of tuneral Service Lice	Much			ss of Facility uneral Ho			land 21009
Physicia /Medic Examine	al	23a. Pan1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	- My OC	eath. Do not ent	the mode of dy	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
68 / 60, tificate be executed g physician and as the burial-transit	edical Examiner		c. Due to (or as a cons Due to (or as a cons						
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C		Physician: To the best of my laminer: On the basis of examiner and manner stated.						
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2x	X	Ene 15	o completed cause of death (I	10 Nort		St., Balt	imore, M	D 21201	
	State istrar	31. Date filed (Month, Day, Year) SEP 0	6 2005 Registrar's Si		Coarde				
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Amend item#10b-c, Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 005 28910 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 2, **Physician** MIGNON BANK SALGANIK 2005 5:10 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death EDENWALD TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours Min. 1 ☐ M 2 💢 F (Month, Day, Year) 03/27/1914 215-22-0769 91 Yrs. MD Usual Residence of Decedent City, Town or Location Hampstead TOWSON 10a. State Carroll 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 ☐ No 10f. Zia Godo 74 18811 "Foreston Road 10g. Citizen of What Country? 800 SOUTHERLY ROAD 21286 U.S.A. Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: WHITE 1 ☐ Yes 2 ☐ No þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER JEWISH COMMUNITY CENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JOSEPH** BANK ANNA 2 HARTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNN SALGANIK / DAUGHTER 18811 FORESTON ROAD-HAMPSTEAD, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI 09/05/2005 OWINGS MILLS, MD ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 1000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ms Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2 No Yes 25. Was case referred to medical 26. Place of Death Chec onl one examiner? Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

or Attending Physician: The law requires that the death certificate be executed P.O. Division of Vital Records,

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.
snt: if item 27 is marked other than "natural", or items 23s or 28s-1 shov ury or other traumatic event. It a Medical Examinar must be intiffed at

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29b. Signature and title of certifie

30. Name and address of

physician

Baltimore, Maryland 21215-0036

the Maryland

State Registrar ~ Rollingty

completed cause of death (Item 23a) (Type, Print)

32. Regi

29d. Date signed Month, Day, Year,

State of Maryland / Department of Health and Mental Hygien 0 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year NATALIE SOBEL **SEPT** 2005 9:35 A /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SPRINGHOUSE PIKESVILLE BALTIMORE **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth OCT.1,1924 Birthplace (State or Foreign Country) 1□M 2₩F Director 218-14-7786 80 Yrs. MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "neturel", or items 23s or 28s-1 ehow other traumatic event, the Medical Examinar must be mailfed at 10d. Inside City Limits Completed by Funeral Director BALTIMORE 1 ☐ Yes 2 🐼 No PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 8911 REISTERSTOWN ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If item 27 Is marked other than 'ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) **CLERK** CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MORRIS **SOBEL** ဂ္ **ROSE** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEATRICE KAUFMAN / SISTER 6317 PARK HEIGHTS AVENUE #611 - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation _5 ☐ Other (Specify) HEBREW FRIENDSHIP CEM 09/02/2005 BALTIMORE, MD Juneral Service Lighnsee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Immediate Cause (Final **Physician** MYO OB WOLD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ Y RONAWSIDS Completed 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20485. person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 6 ASSON 1. 31. Date filed (Morth, Pay Year) 2005 Registrar's Signature State Registrar

			For State Registrar	State	of Marylar		artment of H			iene 2005	28912
	۰		1. Decedent's Name (First, Middle,	Last)					2. Date of Deat	h	3. Time of Death
	Physici /Medio		Maharanie S:	ingh					Septemb	Day Year Der 2. 200	8.4
	Examir		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, or	Location of Death		4c. County of De	
			Washington Adv				Takoma			Montgom	ery
	Funeral			3.Sex 1 □ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		213-02-8833 Usual Residence of Decedent		/	7 Yrs.			Nov. 27	, 1927 Gu	yana
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
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	ar de tems	nue	11. Marital Status	Armed F	cedent Ever in U orces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite. etc.
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. After than "natural", or tems 23a or 28a-f show ent, the Medical Examiner must be mailified at	ed	15. Decedent's		Jaies.	16a. Dece	dent's Usual Occupa	ation		AS 16b. Kind of Busines	ian Indian
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7	d with giene	Com	11	Ourings (Self-	Employed			Retail	
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, La	ist)				18. Mother's Nan	ne (First, Middle, M	fa <i>iden Sum</i> ame)	
<u>ya</u>	ould I Meni arke	To	Shiv Persand					Bet	tty Singh	<u> </u>	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examilier in usi be nullised at ones.		19a. Informant's Name/Relationshi							City or Town, State,	
	1 and tealth		Terath Singh/So 20a. Method of Disposition	on	20h F	8804	Bradford sition (Name of	Road, #1		Spring,	
Baltimore,	ages nt of l t: if it		1 ☐ Burial 2 🛣 Cremation 3		_	emetery, crer	natory or other place	Dep	ember	20c. Location - City o	r Town, State
₽	urtme artme ortant injury		* 4 □ Donation 5 □ Other (Spe 21. Signature of □ Oneral Service Li		Cre	emātori	um, Inc.	5, 2	2005 B	ethesda,	Maryland
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П	Physician	7	shock, or heart failure. List or Immediate Cause (Final		cure.	W	CNAI	Carel	/ ~~~ 1	1.10.	Interval Between nset and Death
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	it the death certific by the attending p tached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗓 No	4☐Pregi	birth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
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ord	w require been si should?	ted							1 🗆 Ye:	s 2 X No 3 □ P	robably 4 Unknown
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Division of	Attandi r death. sctor: A sy the fu	ifica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place	of Injury - At ho	me, farm, stre	eet, factory, office		28f. Location (Stre	eet and Number or R	ural Route Number.
S	s after	Certification:	4 ☐ Homicide determine	build	ing, etc. (Specify	1)	,,		City or Town,	State)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one)	aminer: On the b	asis of examinal	wledge, death	occurred at the time	e, date and place, inion, death occur	and due to the car	use(s) and manner as te and place, and due	s stated.
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and man	ner stated.		29c, License			d. Date signed (Moni	
	/		Salun	Han	M	9		8486		STP. 1	در
	b		30. Name and address of person wh	o completed caus	se of death (Item	23a) (Type I		()	1 -	- Com	
				AZ12			11 Avenue	. Takoma	Park M	arvland ?	0912
• • •	Sta	100	31. Date filed (Month, Day, Year)	32. P	Registrar's Signa	ture		, _unoma	LULING ITS	aryranu Z	V J hale
E.	Registr	ar	SEP OR ZI	Ub Ro	our of	Ace	de				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Kristalo Tangires 2:00 AM 31, 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4224 Frederick Avenue Baltimore N/A 5. Social Security Number 8. Date of Birth Day, Year 1908 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Asia Minor **Funeral** Days 1 □ M 2 XF 96 Months Hours Min 217-48-8246 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hydiene. 10a State 10b. County 10c. City, Town or Location itam 27 is marked other than "naturel", or itams 23a or 28a-f show other traumatic event. If a Medical Examinar must be notified at 10d. Inside City Limits 1X Yes 2 □ No Completed by Funeral Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4224 Frederick Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNK. Maria UNK. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina M. Memphis, Grand daughter 4224 Frederick Avenue Baltimore, Maryland 21229 itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. 09/02/05 *4 □Donation 5 □Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signatura of Funeral Service Use see 22 Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Atheroscleratio disease or condition resulting in death) ardiovascular Pars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown þ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ihis 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38762 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shafon J. McCorna (k MO) old 5411 Baltimore, 21229 31. Date filed (Month, Day, Year) 2005 Regis ar's Signature Registrar

5-05827 evin Todd JD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

odd		1- State Unpend Item 23a Registrar Amend Item 2	State of Marylan	d/Depa	artment of	Health 26-0	and Mental H	ygiene	2005	28914
Physicia	an	1. Decedent's Name (First, Middle, Last) Kevin Lee Todo		me Cei	rtificate of	Death	2. Date of E Month Augus	Death Day		3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give st Saint Agnes Hospita	reet and number)		4b. City, Town, Baltimo	re	of Death	4c.	County of Death	
Funeral Director		5. Social Security Number 6. Sex 216-88-0215	7. Age (In yrs. 41	last birthday) Yrs.	If Under 1 Yea Months Day			Day, Year)	Cou	aplace (State or Foreign intry) aryland
a-f show	ρį	10a. State 10b. County Maryland N/A	10c. Cit	by, Town or Lo Balt	imore					10d. Inside City Limits Y⊟ Yes 2 □ No
23a or 28.	ai Director	10e. Street and Number 308 N. Hilton S	treet		10f. Zip Code	21229			zen of What Cou ISA	untry?
r, or items	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			ban, Mexic	rigin? (Specify Yes or f an, Puerto Rican, etc.) v:		14. Race - Amer Black, White Specify:	
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Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-f ehow eny injury or other treumatic event, the Medical Examiner count be multiled at once.	Be	12th grade 17. Father's Name (First, Middle, Last) Samuel L. Todd,	Sr.	Sec	urity_	1	.cer her's Name (First, Midd tty Anders	le, Maiden	ote Ci	ompany
ith and Me 27 le mark r treumatic	ပ္	19a. Informant's Name/Relationship (Type Tia King-Todd/ W	e, Print)	19b. Mailii 308	ng Address <i>(Stre</i> N. Hill	et and Num	ber or Rural Route Num Street Bal	ber. City o	Town, State, Zi	ip Code) ryland
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ate has been si page 2 should I	Completed	Cardiovascular Dis					24a. W au pe	topsy rformed?	24b. Were au prior to death? Yes	topsy findings available completion of cause of 2 No
er this certiticate has eral director, page 2	n: To Be	27. Manner of Death	ospital: 1 ☐ Inpatient 2	ER/Outpatie	III 3 DOA	ther: 4 🗆 I	ce of Death Check online Nursing Home 5 Re 28d. Describ	sidence (ufy)
within 24 hours etter death. To the Funerel Director: Atter this centificate has been signed by the attending p gompletaly tilled in by the funeral director, page 2 should be detached for use as	Certification:	Tanatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8-29-05 28e. Place of Injury - At houilding, etc. (Speci	11:40	a ^M 1	∐Yes 2 <mark>X</mark>	28f. Location City or	(Street an Town, State	ock his 308 N. Maryland	ral Route Number Hilton Stre
in 24 hou he Funer pletaly tiil	edical		er: On the best of my known: On the basis of examination and manner stated.					e, date and	place, and due	to the cause(s)
10 10 m	Σ	29b. Signature and title of certifier Labitelle	al AR	٢	0.	nse numbe C.M.E		Aug	gust 30,	2005
, A.		30. Name and address of person who co	474		111	Penn	Street, Bal	timor	e Maryl	and 21201
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	M A	artis					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 28915 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer 11:30 a_M Mary Sue Thomas 8 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Irvington Balto If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛚 F Director 64 Yrs 214-38-7695 12-28-1940 N.C. Usual Residence of Decedent death with the Maryland 10a State 10b. Count 10c. City, Town or Location 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner most be mutilised at 10d. Inside City Limits Director 1 X Yes 2 No N/ABalto Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Druid Park Lake Drive Apt 806 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Itel 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Thomas Mildred Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum <u>once.</u> 7688 Anvil Drive Frederick, Md 21701 Donnell Dailey - Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9-3-2005 Catonsville, Md Metro Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician o (or as a consequence of): toular disease or condition resulting in death) musto /Medical Due to (or as a cy **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 cu 1 ☐ Yes 200 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No manus certificate has autopsy performed PZ No Yes To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 1 ☐ Yes ② No Cther: 2 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28c. Injury at) Work? 28d. Describe how injury occurred 28b. Time of After t Certification: Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director. 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)25044 30. Name and address of myho completed cause of death (Item 23a) (Type, Print) MONDS FERRY Rol BATTO MD 2122 32. Segistrar's Signature State 6 2005

Registrar

State of Maryland / Department of Health and Mental Hygiene 2005For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2005 **Physician** DIANE M. THORNTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITON ROSE A O C If Under 1 Year If Under 24 Hrs. Franklin Sq Ba uo1e -1 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2⊋F Yrs. Director 217-84-3470 March 3, 1969 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10b. County 10a, State 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Director MD. BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6630 RIDGEBORNE DRIVE Funeral 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) llth SCHOOL BUS DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental h Be RAY JOHNSON BELINDA JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6630 RIDGEBORNE DR. LEONARD A. THORNTON/HUSBAND ROSEDALE, MD 21237 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9-7-2005 BALTIMORE, MD 22. Name and Address of Facility William C. Brown COmm. F/H P.A. 1206 W. North Ave. Baltimore, MD 21217 Approximate
Interval Between
Onset and Death

MONTH 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician · Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 2 No **Division of Vital** 1 Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No investigation after death Director: / I in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide filled 24 hours a e Funerel (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signatyme and title of certifier 29d. Date signed (Month, Day, Year) easaclam M.D, 09-01-2005 DH5530 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 200 Philadephia road, Baltimore MD 2123 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 6 ZUUD Believe & Sperker Registrar

	•	For State Registrar	State of M	aryland	/ Depa	artment rtificate	t of H	ealth a Death	and M	lental Hy	ygiene Reg. No		5 2	28917
Dhomin		1. Decedent's Name (First, Middle, L	ast)			· ·		-		2. Date of D Month	eath Da	y Yea		. Time of Death
Physici /Medi		John Lee Tu	rner							Augus				23:44 M
Examir		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of	of Death			. County of D		
		Washington Adve		ital ge (In yrs. las	et hirthday	Tako If Under		Park If Under	24 Hrs.	8. Date of B	irth	Montgo		(State or Foreign
Funeral Director		5. Social Security Number 5.79–34–3095	1 X M 2 □ F	78 78	Yrs.	Months	Days	Hours	Min.	Mar.	ay, Year 15	1927 W.	Country)	
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yland		10a. State 10b. County		10c. City,	Town or Lo	ocation								Inside City Limits
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-1 show dieal Exeminat must be notified at	Director	Maryland Montgo	mery	Beth	esda									1 ☐ Yes 2 🏹 No
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er de Items	nue	11. Marital Status	12. Was Decedent Armed Forces	?	. 13.	was Deced If Yes, spec	ent of Hi	n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	10+	Black, W		
36 Ir, or	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 M Yes 2 □ If Yes, Give Year or Dates:	Worl War	d TT	1 ☐ Yes 2	No XI	Specify:				Specify:	Whit	e
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yla buld the Meni	ဥ	Lee Thomas Turn								gstack	_			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exemples input be notified at once.		19a. Informant's Name/Relationship										or Town, Stat		
e, I 1 and 1 ealth 1 ealth 1 mm 27		Robert E. Sengs 20a. Method of Disposition	tack/Cousi	20h Pla	ce of Diene	settion /Nam	na of			Date		rsburg ocation - City		20879 State
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Ba perm Depa Impo any i		21. Signature undar Service Ele	כו	M0080	13 Be	thesc	la-Cl	nevy	Chas	e, Inc	: 75	57 Wis	cons	ral Home/ in Avenue
		23a. Part 1. Enter the disease, or co	mplications that cause	d the death.						20814- or respiratory			Ap	proximate
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cords, w requires been sign	d by	Pressure Sore,	Chronic O	bstruc	tive	Lung	Dise	ease		1 🗆	Yes 2	. X No 3 □	Probably	y 4 □Unknown
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g Phy gerthii eral c		27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time o		8c. Injun	y at		28d. Describe	how inju	iry occurred		
ision (ttanding I death. ctor: After	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	ay rour,	injury	М		Yes 2	No					
Division of Vital Records, to Attanding Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not determine	280. Place of II	ijury - At hom	ne, farm, st	reet, factory	, office			28f. Location City or T	(Street a	nd Number or e)	Rural Ro	oute Number,
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St	ate	SED U.C.	A.		1	racks								

			_ For	partment of Health and Mertificate of Death		ene 2005	28918
	*		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Robert Sylvester Traynor		September	1, 2005	5:45 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			Shady Grove Adventist Hospital	Rockville		Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Davs Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		358-14-6/22		May 14, 1	1925 Penn	sylvania
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location			10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "netural", or Itams 23e or 28a-f show the Modical Exami ar must be notified at	ō	Maryland Montgomery Rockvil	1 a			1X Yes 2 No
	the t	Funeral Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	untry?
	With 30 or	0	1941 Lewis Avenue	20851		United St	ates
	ms 2	era	11 Marital Status 12 Was Decedent Ever in U.S. 1	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecity Yes or No-	14. Race - Amer	ican Indian,
9	or Ita	F	1 Never Married 2 Married 1 Never Married 2 No	1 ☐ Yes 2 ☒ No Specify:	nicari, etc.)	Black, White	White
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Itam 27 is marked othar than "netural", or Itams 23e or 28a-1 show other traumatic evant. Its Modical Examinational Le notified at		,	824 Cochrane Court,			20879
Ġ,	of Health itam 27 i		20a Method of Disposition 20b. Place of Di	sposition (Name of	Date 2	20c. Location - City or 1	Town, State
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Baltimore,	- 555			22. Name and Address of Facility Libert A. Pumphrey Fune			
ä	Departiment Important Impo		Milliam A. Hunshren M01173	300 W. Montgomery Avenu	rai nome, e, Rockvil	ROCKVIIIE, I Lle, Maryland	nc. i 20850
60			23a, Part1, Enter the disease, or complication; the t caused the death. Do not				Approximate Interval Between
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<u>></u>	lysician: is certific director,	OB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Resider	nce 6 □Other (Spec	ify)
o	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 Shatural 5 Pending (Month, Day Year) 28b. Tim (Month, Day Year)		28d. Describe hor	w injury occurred	
jo	uttandin death. ctor: Af y the fur	atic	2 Accident investigation	M 1 □ Yes 2 □ No			
<u>≤</u>	r Attu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru. , State)	ral Route Number,
Q	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the						
	Hosp 4 hou Funa ely fil	edical	29a. Certifier (Check only (Ch				
	tha hin 2 tha mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c, License number	29	d. Date signed (Month	. Dav. Year)
	To With		250. Signature and time of continer	W D3876	2 6	seor 2	7005
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	1841		30. Name and address of person who completed cause of death (Item 23a) (Ty	po, Print) 401 Reseaved	a Rill	O Suito 3	Sockialon
130	Sta	to.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 1	1700	<i>y</i>	W COULLY !!
	Regist		SFR 0 6 2005 Reven 15 19	neces			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** WINGFIELT ROWENA AUGUST 30, 2005 1802 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMORE CITY 2701 MT. HOLLY STREET If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Yrs 216-20-7670 OCTOBER 21,1926 MARYLAND Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28e-f ehow th and Mentel Hygiene. ?7 is marked other than "nature!", or items 23s or 28e-1 ehov traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No BALTIMORE Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. A. STREET 21216 permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23s apply lighty or other traumatic event, the Medical Examinar mountaine. 2701 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Community College of Battimore FACILATATOR YEARS 18. WANN Tare (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CARTER CARTER CLARENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. WINGFIELDSR. 2701 MT. HOLLY ST, BALTIMORE, MD 21216 SOHN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CARRISON FOREST CEM. 09-09-2005 OWINGS MILLS, MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
503EPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIMORE, MID 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asphyxia and b Due to (or as a consequence of): **Physician** blunt force lyunes /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a existeduance off Examiner Attending Physician: The law requires that the death certificate be executed burial-transit ettending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No this certificete 1⊠ Yes 2□ No 25. Was case referred to medical 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Hospital: 1 Inpatient Medical Certification: To 1 Tyes 2 □ No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Donth, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Ajury 1 Natural 5 ☐ Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 Yes 2 XNo subject assaulted 8/30/05 6:00 PM investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 2701 Mt Holly St j But house, M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide i But hourse, MD home 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Joes 2005 **OCME** AUGUST 31, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2. Registrar's Signature

31. Date filed (Month, Day, Year) SEP 0 6 2005

Greensen

M.D. 111 PENN STREET, BALTIMORE, MARYLAND

State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8 **Physician** 28^{bay} 2005 10:30 а. м Minerva W. Williams /Medical 4c. County of Death N/A 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Balto Augsburg N.H. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 F 214-40-5175 90 Pa Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23e or 28e-f show the Madical Examinational be notified at 1 Yes 2 □ No Director N/A Md Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1912 N. Bentalou Street 21216 USA filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ 3 ₩ Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Baltimore City Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importent: If item 27 Ia marked other It eny injury or other traumatic avant, ITS ONCE. 12th grade 4 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Morris Wesley Beatrice 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Re-Elda Williams - Daughter Balto, Md 21216 1912 N. Bentalou Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State ^¹ 4 □ Donation 5 □ Other (Specify) 8-31-2005 Arbutus Memorial Arbutus, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 art1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death In ediate Cause (Final disease or condition re-ulting in death) End Stage Physician /Medical Due to (or as a constituence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 20 No 1 Yes 1 Yes Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ⚠ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Kursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Yes 2 No death. investigation 2 Accident after death filled in by the 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park Heights Avenue 7220 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			State of Maryland / Department	artment of Health and tificate of Death		ene 2005	28921
	DI		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Barbara J. Wil		8	28 2005	11:30 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Deat	h
L			Blue Point N/H 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Balto If Under 1 Year If Under 24 Hrs	8. Date of Birth	N/A	holace (State or Foreign
	Funeral Director		213-34-2548 1 M 2 M F 67 Yrs.	Months Days Hours Min.		938 Co	hplace (State or Foreign buntry) N • C •
			Usual Residence of Decedent				
	show	_	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits X☐ Yes 2 ☐ No
	Ba-f	Director	Md N/A Balto 10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	
	with t		803 Brooks Lane	21217	109	U S A	dittiy:
	leath	Funerai		Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	specify Yes or No-	14. Race - Ame	
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3	be filed within 72 hours after death with the Marylan Hygiene. At Hygiene. Ad other than "natural; or Items 23a or 28a-f show event, the Marylan Examinating the redifficult.		17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	iden Sumame)	
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Ž	and 2			8 Brighton Street		Md 21216	
ב ב	es 1 a of He of He fiterr r oth		20a. Method of Disposition 20b. Place of Disposemetery, cref	natory or other place)		c. Location - City or	•
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Dar	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, trainsone.		21. Signature of Funeral Service Upensee 22	Name and Address of Facility. 4300 T		H West nue Balt	o, Md 21215
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	tificati g phy as the	e e					
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	6		30. Name and address of person who completed cause of death (Item 23a) (Type.	FIS ME	40E	2121	5
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cer</i>	rtmen tificat	t of H	ealth a			Reg. No.	005		
	Physici	an	1. Decedent's Name (First, Middle, I	,							2. Date of Dea	Day	Year	3. Time of	
	/Medic			WHITEHEAD							Septemb				a [™]
	Examin	er	4a. Facility Name (If not institution, g	ive street and number)			-	_	Location o	of Death			County of De vard	atn	
			8703 Teresa Lane 5. Social Security Number 6.	Sex 7. Age	a (In vrs. I	ast birthday)	Laur If Under		If Under 2	24 Hrs.	8. Date of Birt	th	9. B	rthplace (State o	r Foreian
	Funeral Director		219-36-9480	1□ M 2√√X 68	o (m) j. o. n	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug 25	Y , $Y \theta \mathbf{a} \mathbf{r}$	937 Ma	cyland	
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	ltam Itam	-un-	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?					n, Mexican	, Puerto F	cify Yes or No Rican, etc.)		Black, Wh		
936	urs af	by	Widowed 4 □Divorced	If Yes, Give Year or Dates:		1	I ☐ Yes	2 1 No	Specify:				Specify:	White	
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and	be fi	Be	17. Father's Name (First, Middle, La Cecil Howes	st <i>)</i>							grove	Maloon	oumame)		
2	should be ind Mental I	P _L	19a. Informant's Name/Relationship	(Type Print)		19b Mailin	n Address				Route Numbe	er. City or	Town. State	Zip Code)	
Maryland	2 4 2 5			/daughter		8703			_		l, Mary	_			
	of Health of Health fitem 27 r other to		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition (Nar	ne of		D	ate	20c. Lo	cation - City	r Town, State	
Baltimore,	permit. Pages in Department of Inportant: If ite any injury or ot once.		1 Burial 2 Cremation 3			Arunde:	-			/08/	2005	0der	nton, 1	Maryland	
alti	mit. F partm portar / injui		21. Signature of Funeral Service Lic			22	Nam a	d Addres	Fu Facilit	yal H	ome, P.	. A .			
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Δ.	de de	by Pł	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	obacco u	se contribute	to the cause of d	leath?
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)	1		1	DE	NI	1.	D	247	21			Sept	. 6, 2	2005	
	7		30. Name and address of person wh										1 -	00707	
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	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ars Signa	ture	Speak	Co. P							

State of Maryland / Department of Health and Mental Hygien 2 1 1 5

28923 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** PM 08.26. BELLE WASHINGTON 2:40 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 5932 ROBINDALE ROAD CATTONSVILLE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗷 F Yrs. 75 08.15.1930 Director 050-28-1897 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intern 57 is marked other than "natural", or itama 23 a or 28a-f show 10c. City Town or Location 10d. Inside City Limits 10a State 10b. County traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Completed by Funeral Director CATONSVILLE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 usa 5932 ROBINDALE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SERVICE BALTO CITY SCHOOLS FOOD 11 TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BENJAMIN GREEN ELOISE WASHINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RD. CATONSVILLE MD 21228 CHARLES WASHINGTON 5932 ROBINDALE other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6 ' 4 ☐ Donation 5 ☐ Other (Specify) 09.02.05 GARRISON FOREST OWINGS MILLS MD 21. Signature of Funeral Service Licens VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATL PIKE, BALTO MO 21229 austr 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2vno **Physician** netastatic colon (ancon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical use as the Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. I 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: A 2 Accident in 24 hour.
The Funeral Direc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30, the and address of person who completed cluse of death (Item 23a) (Type bunQue BALT MUD 21229 200 nole 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 6 2005

State of Maryland / Department of Health and Mental Hygien 2005

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			1 - State Registrar		C	ertificate of	Death		Reg. No.	20724
	Dh!.		1. Decedent's Name (First, Middle	a, Last)			1. 71.	2. Date of De.		3. Time of Death
	Physici /Medic		Helen L. Wh	iteley				August	31 2005	9:55p M
	Examir		4a. Fecility Name (If not institution	n, give street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
			14269 Triadelph			Dayton			Howard	
	Funeral		5. Social Security Number 317-01-8813	6. Sex 7. Age ((In yrs. last birthda	y) If Under 1 Year Months Days		8. Date of Birt (Month, Da	th y, Yeer) 9. Bi	rthplace (State or Foreign ountry)
	Director			7C3 E.M.	87 Yrs.			Sep. 17	, 1917 Oh:	
	and		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	Location				10d. Inside City Limits
	Marylan f show	5	MD Howai							1 X Yes 2 □ No
	the 28a-	Director	MD Howan	.u	Highland	10f. Zip Code			10g. Citizen of What C	
	with 3a or	0		Count		20777	,			outiny :
	ter death Items 2: Inst. mus	Funerai	13443 Chrismar	12. Was Decedent Ev	rer in U.S. 1	3. Was Decedent of If Yes, specify Cub		pecify Yes or No-	U.S.A. - 14. Race - Am	erican Indian,
9	after or Ite	Ē	1 Never Married 2 Marri	Armed Forces? ried 1 ☐ Yes 2 🖺 No				o Rican, etc.)	Black, Whi	te, etc.
Ö	72 hours after death with the Maryland neturel', or Items 23a or 28a-1 show disea Examiraer must be rodified at	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:		Specify: WI	nite
21215-0036	be filed within 72 hours after death with the Maryla tal Hygiene. Id other than "neturel", or Items 23s or 28s-f show event, the Medical Evartinat must be notified at	Completed	15. Deceden	t's Education st grade completed)	16a. De	cedent's Usual Occu ve kind of work done	pation during most of wor	kina	16b. Kind of Business	Industry
21	within ene. than "	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retire	nd)	9		
2	e filed within al Hygiene. I other than vent, the M		17 Fatharia Nama (First Hiddle	2	Bool	keeper	40.14 + 1.14	(5:	Federal G	overnment
and	be fi	Be	17. Father's Name (First, Middle,						Maiden Surname)	
Sla	should be nd Mental marked o	7	Charles A. Kunk					L. Harr		
Maryland	nd 2 state ar		19a. Informant's Name/Relations Eleanore Ellene			-			er, City or Town, State, $ ext{d}$, MD 20777	. ,
Baltimore,	es 1 ar of Hea if item ir othe		20a. Method of Disposition 1 Darial 2 Cremation	3 □ Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Location - City or	Town, State
Ë	Pages Iment of tent: If it		`4 □ Donation 5 □ Other (S		Fort Lin	coln Crem	atory 9/2	/2005	Brentwood,	Maryland
Balt	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service	Licensee		22. Name and Addre	oln Funer	al Home		
			23a. Part1. Enter the disease, or	complications that caused th	ne death. Do not e				ntwood, MD	20722 Approximate
, III	0.00		shock, or heart failure. List Immediate Cause (Final	only one cause on each line.	•		,	- · · · · · · · · · · · · · · · · · · ·		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		e Dement	ia				Years
	Examiner			Due to (or as a c	consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):					
V	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	certificate be executed ding physician and se as the burial-transit	Ex	resulting in death) Last	Due to (or as a c	consequence of):					
68760,	ite be iysicii ne bu	edicai		d						
39	ng ph	/Med	IF FEMALE:							
Вох			23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2		3□Ectopic pregnanc	y		23d. Date of de	,
	The law requires that the death ate has been signed by the atter bage 2 should be detached for L	Physician	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4 ☐ Pregnant at tin	ne of death 5	Other (specify)			Month	Day Year
P.0	that the ed by detacl		Part II. Other significant condition	ans contributing to death but	not reculting in the	undertwing equal on	on in Part I	220 Did to	bacco use contribute to	the course of death?
ŝ	signe signe	1 by	Tarri, othor significant conduct	and continuously to death but i	not resolding in the	underlying cause giv	en in Fait i.			robably 4 Unknown
0.0	w requir been si should	etec								
Vital Records,	has has ge 2 s	ompieted						24a. Was a autop	sv prior to	utopsy findings available completion of cause of
a		O	05.14					perfor 1□ Yes		2□ No
Ξ	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	a∏ 50/0 · · ·	Ott Do. Ott	26. Place of Dea			Assisted
of		-	27. Manner of Death	28a. Date of Injury (Month, Day Y	2 ER/Outpati	GILL DUA	4 🗀 Nursing m		ence 6 XOther (Spe ow injury occurred	city) Living
ion	Attending F r death. actor: After by the funer	ation	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig		(ear) Injury		rk? Yes 2 □No		. ,	
Division	of or Attendia after death. I Diractor: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of Injury	- At home, farm,	street, factory, office			treet and Number or Ru	ural Route Number,
Ö	tel or rs afte el Dira ed in b	Certification	TO HOME OF	building, etc. ((эрвспу)			City or Tow	n, State)	
	To the Hospitel or At within 24 hours after or To the Funerel Dirac completely filled in by	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of r Exeminer: On the basis of ex	xamination and/or	ath occurred at the til	me, date and place, opinion, death occur	and due to the c	cause(s) end manner as date and place, and due	s stated. e to the cause(s)
	o the vithin 2 o the omple	Mec	29b. Signature and title of certified	and manner state	a	29c. Licens	e number	2	29d. Date signed (Mont.	h, Day, Year)
	->-0		/a/	MO		D5186	60	q	eptember 1	2005
•	0		30. Name and address of person		th (Item 23a) (Typ				opcomber 1	, =000
	3		Jonathan Fish,	MD 10700 Char	cter Dr.		umbia, Ma	ryland :	20194	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature					
	Registr	ar	SEP 0 6 2	2005 Me	16 Por	20/2				

NATKINS

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygien 2055

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Watkins Month Day **Physician** AUGUST 31 5:18 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NIA LIUSPITAL OF BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday). 5 7 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours -46-5822 25, 1948 marylana Director Usual Residence of Decedent the Maryland Od. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Baltimore Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 714 Benjamin Quarles Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 20 Married 1□ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be f Mental h George Martha 19a. In ormant's Name/Relationship (Type, Print) and 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 I emeny Injury or other Alexander Sparks, md 21152 Chase Walkins - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem Park 4 □Donation 5 □ Other (Specify) 21. Signature of Fineral Service Lice R2. Name and Address of Facility Funeral of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DUE Physician DEPSIS MONTHS TO STAPH + ENTEROBACTER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit requires that the death certificate be executed signed by the attending physicien and do be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HEART 1 Yes 2 No 3 Probably 4 Unknown ONGESTIVE peeu DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 2 No Z Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 Z No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 2 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 0 M.D. RES-000 AUGUST 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NWANKWO SINAI HOSPITA C M.D. BALTIMONE [KECHI JOHN 32. Registrar's Signature 31. Date filed (Month, Day, Year) Coarie State SEP 0 6 2005 Registrar

Williams, Berjamin Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep Registrar Co	partment of Health and Mertificate of Death		ene2005	28926
	Physici /Medic		1. Decedent's Name (First, Middle, Last) BENJAMIN WILLIAMS , III		2. Date of Death Month Avoyst	Day 2005	3. Time of Death 22:50 м
	Examir	AL.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Smai Hospital of Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Baltimore C'	8. Date of Birth	NA	Chata a Farin
44. *25.	Funeral Director		220 · 64 · 8180 1 M 2 F 47 Yrs. Usuaf Residence of Decedent	Months Days Hours Min.	(Month, Day,	Year) Year) 9. Birthpi Coun	ace (State or Foreign try)
	yland		10a. State 10b. County 10c. City, Town or I	ocation		10	0d. Inside City Limits
	Ba-f a	Funeral Director	MD BALTIMORE GWYNN	OAK			1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
	ne 23	era	3700 WOODBINE AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S.	21207 . Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Americ	an Indian,
9	or iter	Fun	Armed Forces? 1 □ Never Married 2 M Married 1 □ Yes 2 M No 1 Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	o Rican, etc.)	Black, White,	etc.
003	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show dires Exacident must be codified at	d by	3 Wildowed 4 Divorced Year or Dates:		1	Specify: BLA	
15-	in 72 n "nat	olete	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work OO NOT use retired)	king	6b. Kind of Business/Inc	lustry
21215-0036	filed within Hygiene. thar than "	Completed	Elementary/Secondary (0-12) 12/14 GRADE College (1-4or 5+) 2 YRS SOC	IAL WORKER		STATE OF	MD
	d al o	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
Maryland	should be nd Mental marked o	^L	BENSAMIN WILLIAMS 19a. Informant's Name/Relationship (Type, Print) , 19b. Ma			WICK STATE OF THE	0-4-1
Ma	2 2 2 3		YOLANDA R. WILLIAMS (WIFE) 1018	ling Address (Street and Number or Rule KEVIN ROAD BA	ITIMORE	-	Q
ē,	of Health of Health fitem 27		20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or To	wn, State
E			1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING PA		3.05 F	PANDALISTON	IN, MD
Baltimore,	permit. Pag Department Important: I any injury o			22. Name and Address of Facility AUGHN C. GREENE FUN 151 BALTO NATL PIKE	ERAL SERV	CE	
N.	AUT		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or head failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	eumonia			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	* N.	Jer	Sequentially list conditions, and the sequential sequen				
V	and I-transit	Examiner	that initiated events c.				
8760,	be exe		resulting in death) Last Due to (or as a consequence of):			- 1	
687	icate l physi s the b	dical	d				
Box (eath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
	a death	sicia	1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.0	hat the de id by the detached		9 Unknown Part If. Dther significant conditions contributing to death but not resulting in the	underhing cause gwen in Part I	23e Did tob	acco use contribute to th	e cause of death?
Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by	Tarris Significant Community to death but not resulting in the	underlying cause given in Part I.		2 No 3 Prob	\ /
00	s been si	Completed			24a. Was an	24b. Were autor	osy findings available
Re	The law cate has page 2	mo			autopsy perform 1 Yes 2	prior to cor death?	npfetion of cause of
/ital	ilcian: Th certificate rector, pag	Be C	25. Was case reterred to medical examiner?	26. Place of Dea	th (Check only one	7.3	
of V	Physician: this certific ral director,	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati			nce 6 Other (Specify	')
	After After fune	tlon	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how	v infury occurred	
Division	or Attending ifter death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, s			et and Number or Rura	Route Number,
Ö	tal or	Cert	4 Homicide building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, de: Cartifying Physician: To the best of my knowledge, de	investigation, in my opinion, death occur	rred at the time, da	te and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, I	Day, Year)
			Holm (oui-	KES-000	A	ugust 29	,2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type A Carinci M.Y	29c. License number RES-OOC B. Print) Sinai He	apital	of Bo His	MOYE
1	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	house	7	J + -001 U/	
	Registr	ar	SEP 0 6 2005 Means 13.	1			

State of Maryland / Department of Health and Mental Hygiene 200528927 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Williams Mary $2\infty5$ 0804 AM August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) NIA Hospital Johns Hopkins 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 🕱 F 216-38-724 Director mai Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other then "naturef", or items 23e or 28e-f show other treumatic event, the Nedical Examinar must be righted at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int. If Item 27 is marked other then "naturel", or ite 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No by Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 9+4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kinkney MILTON Jehnson marian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) montpelier St. Sister 903 Thompson Marian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) permit. Page Department o Importent: If any injury or once. injury or Jept. 7, 2005 rownsville Vet. Clm. 21. Signature of Far eral Service Licens 22. Name and Address of Facility 270 FredHILTON Pass Gary P. march Rineral 23a. Part Epfer he alsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDAL INFARCTION Bacto, md. 21229 Approximate Interval Between Onset and Death Physician hour /Medical Due to (or as a consequence of) Examiner CORONARY YEARI ARTERY S. mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAI DIJEASE 2 🗌 No 3 Probably HYPERTENSICH 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy HYPERCHOLESTELOUEMIA 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death Check on one Hospital: 1 Inpatient 2XER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Doth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel within 24 hours a To the Funerel I Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicaf Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00052470 09-02-2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Hospital 600 N Wolfe St Batto MO 21287 Fine MD The Johns 32) Registrar's Signature 31. Date filed (Month, Day, Year) Registrar SEP 0 6 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28928 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Month John Douglas Waugh /Medical 2005 1125 August 31 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Yrs. 099-28-8574 68 Director New York Usual Residence of Decedent with the Maryland 10a. State 10b. County in then "natural", or Itema 23s or 28s-f show the Medical Examinar must be multiled at 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Edgewood 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Freys Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Human Factors Engineer 5+ U.S. Government other injury or other traumatic avant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any ling yor other traumatic avent pice. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John T. Waugh Helen (UNK) (UNK) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane S. DeVoe/Executor 2913 Toddsbury Court, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 9-3-2005 Darlington, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Efter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cell Cancer of Lung 3 months Non-Small /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Waugh, John Douglas Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? ģ 2 No 3 Probably 4 ☐Unknown Completed s certificate has b lirector, page 2 si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performe 1 Yes 2 NO the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manyer of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 🗋 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 2 North Avenue

32. Registrat's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2005

J. Kevin Lynch 31. Date filed (Month, Day, Year) D35012

Bel Air, Md.

September

Physic	ion	1 - For State Registrer 1. Decedent's Name (First, Middle, La	ast)		Certificate of	Dealli	2. Date of Dea	ith Day	Year	3. Time of Death
/Medi		JULIUS			WESTHEIME		Augu	st 31.	2005	603P
Exami	ner	4a. Facility Name (If not institution, gir Sinai Hospita	el - Bal	timore	Balt	or Location of Death			y of Death	N/A
Funeral Director			Sex 1 M 2 F	7. Age (In yrs. last birt. 88	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day SEPT 6	1916	9. Birthpla Count	ace (State or Fore
how		10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Lim
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3e or		8002 BRYNMOR CO	OURT #503	3	10f. Zip Code	21208		rog. Chizeri o	Winat Count	USA
teme 2	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	13. Was Decedent of If Yes, specify Cul		ecify Yes or No- Rican, etc.)	14. Rac Bla	ce - America	an Indian,
naturel', or Iteme 23e or 28e-f ehow Item Examiner must be notified at	b	1 Never Married 2 M Married 3 Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Da	2 No tes:	1 □ Yes 2 🂢 No			Specif		WHITE
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giene.	Comp	Elementary/Secondary (0-12)	4 College (1-	4or 5+) ST(OCK BROKER			FINANC	IAL	
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and Ment Is marked aumatic	10	MILTON 19a Informant's Name/Relationship	(Type, Print)		HEIMER Mailing Address (Stree	HELEN	al Route Numbe	r. City or Town	. State. Zip (GUTMAN Code)
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of Heal f Item 2 r other		20a. Method of Disposition 1 XX Burial 2 ☐ Cremation 3 [□ Removal from S	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ace)	Date	20c. Location	- City or Tov	vn, State
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Depart mport iny Inj		21. Signature of Juneral Service Liqu	priiee		22. Name and Addr	30	L LEVINS		-	
		William Indiana	Mug	used the death. Do a		TERSTOWN				1D 21208 Approximate
		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	y one gause on ea	ch line.	ot enter the mode of dy	ing, such as cardiac	or respiratory an	rest,		Interval Between Onset and Deat
ysician Medical		disease or condition resulting in death)	a	Cardio	ce Arry	thmia				
aminer	1		240 10 (0		.,.		Sees . C	7		
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DHMH 17 Rev 1/2001

Calvin R. Young 05-5816 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7010			1 - State Unpend Item	State of Maryland 23a, 27, 28a-f pe	d/Depa er me Cei	ortment of 1847 9 Tificate	of Health ar 12=05 ta of Death			2005						
	Physicia /Medic	an	1. Decedent's Name (First, Middle, La Calvin R.	loung				Au	gust 29	, 2005	3. Time of Death 12:07 P M					
	Examin	er	4a. Facility Name (If not institution, giv			,	wn, or Location of	Death	4c.	County of Death	Δ					
>-			Johns Hopkins Hos			If Under 1 \		Hrs. 8. Date	of Birth	9. Birth	place (State or Foreign					
16	Funeral Director			DYM 2□F 5	/ Yrs.	Months C	ays Hours	Min. 1 Mon		-B GOU	argland					
			Usual Residence of Decedent	10. 0	-						10d. Inside City Limits					
	the Marylan 28a-f show	ctor	Maryland 10b. County /	B	altir						1 X Yes 2 □ No					
	th with th	Funeral Director	10e. Street and Number 1946 Eastda	le Road			1224		Un	izen of What Cou	tates					
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21215-0036	within 72 hours ene. then "naturel", ne Wedical Ext	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual C kind of work of DO NOT use Lif-	done during most o retired)	4		ind of Business/li	Industrial Co.					
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	is 1 and 2 should be 1 of Health and Mental I item 27 is marked or rother traumatic eve		19a. Informant's Name/Relationship (Sherrell Parke	r-Wite	1940	lo East		oad Ba	1 hmor	e, MD.	21224					
Baltimore,	permit. Pages 1 a Department of He Important: If Item eny injury or oth		20a. Method of Disposition 1	Removal from State	emetery, crei		enckry	ept. Date 6 2005	Be		e, MD.					
Balt	permit. Departimport eny inj		21. Signatur of Fuperal Service Lice	the		0.0.80	Address of Facility	BUTTO	Core, N	l Service	a 21007					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Narcotic (Ox Due to (or as a conseq b.	kycodoi uence ol):				tory arrest,		Approximate Interval Between Onset and Death					
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Ical	dical Examiner	Ical	Ical	Cal	Ical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
P.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic preg			_	23d. Date of deli Month	very Day Year					
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cau	se given in Part I.	239		use contribute to	the cause of death?					
Division of Vital Records,	hysicien: The law re his certificate has bee I director, page 2 sho	Completed						_	Was an autopsy performed?	death?	topsy lindings available ompletion of cause of					
/ita	cian: ertific	Be (25. Was case referred to medical examiner?	11				of Death (Check	only one)							
on of \	ding Physi h. After this o tuneral dire	lon: To	1XXYes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Pospital: 1 ☐ Inpatient 28a. Date of Injury Found: Day Year)	28b. Time of Formal 5:05		Other: 4 Nurs Injury at Work? 1 Yes	28d. Des	Residence cribe how injure	6 ☐Other (Spec ry occurred	unk					
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			30. Name and address of person who	AN	11	1 Penn	Street,	Baltimor	e, Mar	yland 2	21201					
	Sta Regist		31. Date liled (Month, Day, Year) SEP 0 6	32. Registrar's Signal	ature /	Sparke	•									

			For State Registrar	State of Maryland		artment of h		lental Hygie	ene 3. No. 20 ()5 289	31
			Registrar Decedent's Name (First, Middle, Last)	Cel	Λ Λ	Dealli	2. Date of Death		3. Time of D	
	Physici /Medic		MARGARE	T JEFFERS	No	ANDE	FRSON	Month		ear 2:52	7the
	Examir Funeral Director		5. Social Security Number 6. Se	LY HOSPITA		1		8. Date of Birth (Month, Day,	4c. County of	J.TG-OM DY B. Birthplace (State or F Cauntry)	2 Y Foreign
	_		Usual Residence of Decedent	. 0				Oct.23,	1923	PG	
	or death with the Marylan tems 23a or 28a-f show ser must be cudified at	ctor	10a. State 10b. County PRINCE (EURLES 10c. City,		REL				10d. Inside City	
	3s or 2	I Dire	10e. Street and Number	MEHN DRIVE	E	10f. Zip Code	20707	100	g. Citizen of Wh		
36	afte or	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of H	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.	
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215	I within 7; jene. r then "n	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	/ life. L	DO NOT use retire	, ,	ing	0		
	be filed w tal Hygier d other th		17. Father's Name (First, Middle, Last)	11/2+ 1	4CCc	UNITRE	1	O (First, Middle, Ma		enment	
Maryland	d 2 should be th and Mental 7 is marked o treumatic eve	To Be	Sypney 19a. Informant's Name/Relationship (7)	JEFFERSON		an Andreas (Chron	MAR	E M	1. JEI	FFERSO	N.
Ma	alth an 27 is 1			ERSON/	1250	1 WOOL	BRIDEE	COURT	2072		
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Baltimor	permit Pa Deparmen Importent: any in ury		21. Signatur of Funeral Service Licens		22	Name and Addre	ss of Facility 3.	CHO'T.	RHIN	ES Cumpa	
Ĺ			23a Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the death, ne cause on each line.						Approximate Interval Betwe	en
И	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Inkestral	B	leedis	9			TWO (A	reck
Į.	Examiner		es income de la Constitución de la Constitución de la Constitución de la Constitución de la Constitución de la	Due to (or as a consequer	ice of):)				Tenye	ears
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequer	nce of):					Tool	1
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.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pregnancy	y		23d. Date of Month	,	ar
1	The law requires that the de ate has been signed by the a page 2 should be detached f	ρ	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the ur	nderlying cause giv	ren in Part I.	23e. Did toba		ute to the cause of dea	
Vital Records,	The law re ate has bee page 2 sho	Completed						24a. Was an autopsy performe	d? prid	re autopsy findings avant to completion of causaft?	allable se of
Vita	Physicien: The this certificate har director, page	Be	25. Was case referred to medical examiner?	lospital:		Oth	0.00	(Check only one)			
of	F = E	n: To	27. Manner of Death	1 L Inpatient 2 ER	Outpatient b. Time of	28c. Injur	4 Nursing Hot	me 5 Residence 28d. Describe how			-
sion	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
Division	after death after death Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number State)	or Rural Route Numbe	r,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tir restigation, in my o	me, date and place, a pinion, death occurr	and due to the caused at the time, date	se(s) and mann a and place, and	er as stated. I due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	ΔΛ.	2	29c. Licens	e number	29d	. Date signed (Month, Day, Year)	
_	0		30 Nam and address of person who co	treened Medici	ne Kh	ysician	DCO60	77 A	Must_	6.2005	
7	Sta	20	31. Date filed (Month, Day, Year)	S Registrar's Signature	ince	Phillip	Drive, C	iney, M	aryla	nd 2083	32
	Registr	-	AUG 2 2 2005	Blem &	Ann	les					

State of Maryland / Department of Health and Mental Hygiene Reg. N2 005 1 - For State Registrar 28932 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:05am M 30, Sr 2005 Charles John Brown August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6917 Plantation Road Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 12, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Hours 1**X**M 2□ F Yrs 82 1922 Virginia Director 214**-1**6-0712 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23s or 28s-f show winer must be notified at Frederick Frederick 1 ☐ Yes 2 📆 🛪 o Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6917 Plantation Road 21701 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural, or Ite 1 XYes 2 No 1942 If Yes, Give
Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White other treumetic event, the Madical Exam þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Engineer Power Company 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Albert Brown Mary Stallings 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m eny Injury or other treum once. 6917 Plantation Road, Frederick, Maryland 21701
se of Disposition (Name of Date 20c. Location - City or Town, State Mrs. Annie A. Brown - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery Sep 2, 2005 Frederick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses

22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick, Maryland21701

23a. Partl. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate
Interval Patrict Immediate Cause (Final **Physician** Spinal Cord Metastases 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 months Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2√ No 3 Probably 4 Unknown Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar of certif D31912 September 01, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julio Menocal, M.D., 1564 Opossumtown Pike, Frederick, Maryland 21702 31. Date filed (SEP) Pax. Year) 2005 32. Registrar's Signa Tre State 160 Registra

State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health and Mental Hygiena 1- State of Maryland / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department of Health Andrew / Department / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 13 Taylor Brann Wilmot Unknown M 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fenwick Landing Senior Care Community Charles Waldorf, MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Month, Days **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Virginia 1**X**M 2□F 07/04/1917 578-14-6925 88 Yrs. **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f aho; other treumetic event, the Mcdical Expriser must be realised at MD Charles Waldorf Director 1 Yes No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Doolittle 11665 Drive 20602 USA Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 13 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill rement of Health and Mental Hy rant: If item 27 is marked oth Be 18. Mother's Name (First, Middle, Maiden Sumame) Brann Willard Taylor Cross ley 2 Lillie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) margaret Eads/daughter 114 Stoney Dr. Hardyville, VA 23070 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ° **= 6** 1

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or Once. July 16, 2005 Village, VA Gibeon Bootist Church *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jones-Ash Funeral Home 3735 Ridge Rd. Heathsville, Vg. 22473 per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Priysician HEART /Medical Examiner CORONARY ARTERY DISEASE S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 □ Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other Sterong Home 5 Residence 6 XOther (Specify) Group ပ 1 ☐ Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Meddal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 53885 2005 30. Name and address of person to completed cause of death (Item 3a) (Type, Print) CAMANAN So lost office # 304 WARDURF MD 16000 32. Registrar's Signature State PARAL. Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2005 28935 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:10 P M Edna C. Burr August 18. 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Montgomery

9. Birthplace (State or Foreign Country) Rockville If Under 1 Year I Tunder 24 Hrs. Brighton Gardens
Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2√□ F Pennsylvania Director 26, 1904 100 215-48-4527 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury again to event, the Medical Examiner must be multiled at any pines. 10a State 10b. County 1 ☐ Yes 2√☐ No Maryland Rockville Directo Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 U.S.A. 5550 Tuckerman Lane Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ☐Yes 2☐No Yes. GiveXX 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 🐧 o Specify: Specify: þ 3 Twidowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Schaeffer Norman V. Stouffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5014 White Flint Dr., Kensington, MD 20895 Edgar S. Burr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 20, Aug. ☐ Burial 2 🛱 🛠 remation 3 ☐ Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2005 Alexandria, Virginia 22. Name and Address of FacilitFrancis J. Collins Funeral Home, Inc 21. Signature of Funeral Service License 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Generalized Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 Yes 2 X No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner 1 ☐ Yes 2 XX0 Other: ٥ 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Xixatural 2 ☐ Accident 5 ☐ Pending 1 ☐Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funaral I 157 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie たり D30132 M-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14804 Physicians Lane #221, Rockville, Maryland 20850 M. Rith Ghosh M.D. 32. Digistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 200528936 Certificate of Death Rea. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** August 18, 12:20 P M Barnett 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Montgomery Woodside Center Silver Spring
If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 😿 F Yrs. Director March 21,1920 Florida 265-18-3001 Usual Residence of Decedent the Maryland 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-1 ahow other traumatic event, the Medical Examinar must be notified at 1⊠Yes 2 No Directo DC None Washington 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō 20012 USA or iteme 23a 520 Aspen Street, NW Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 X Widowed 4 ☐ Divorced White "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event any injury or other traumatic event ans. 17. Father's Name (First, Middle, Last) Be Jewel Polk Womble Williams James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 520 Aspen Street, NW Washington, DC 20012 Lynn Barnett Daughter 20b. Place of Disposition (Name of cometery, crematory of other place)
Metropolitan Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Aug. 20, 2005 Alexandria, Virginia Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Will Eton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Failure to Thrive 6 months /Medical Due to (or as a consequence of): Examiner years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) P.O. I cete has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗌 No 1 Yes 2 🔯 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 🗌 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a
To the Funerel C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 38262 August 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 2401 Research Boulevard #330 Rockville, Maryland Anurita Mendhiratta,

State Registrar

AUG 22 2005

31. Date filed (Month, Day, Year)

2. Registrar's Signature

	State of Maryland / Department of Health an 1- For State Registrar Certificate of Death	d Mental Hygien	
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	3. Time of Death
/Medical Examiner	James Kent Bussey 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I		19 2005 /:50 P [™] c. County of Death
	203 Red Lion Branch Road Millington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8 Date of Birth	een Anne's 9. Birthplace (State or Foreign Country)
Funeral Director	216-36-1831 1XM 2 F 64 Yrs. Months Days Hours	Min. (Month, Day, Year	1941 MD
ehow ehow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
death with the Maryland ms 23e or 28e-f ehow frmust by retified at any and a Director	MD Queen Anne's Millington	140- 0	1 ☐ Yes 2 🛣 No
with the se or 24	10e. Street and Number 203 Red Lion Branch Road 21651	10g. C	itizen of What Country? USA
ours after death with the Maryla els, or Items 23e or 28e-f elvo. Exactlified at Exactlified at by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If Yes, specify Cuban, If Yes,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
	3 ☐Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Specify: White Kind of Business/Industry
be filed within 72 hourst let Hygiene. d other then "neture event, I're Medical Be Completed	(Specify only highest grade completed) [Give kind of work done during most of life. DO NOT use retired) [Give kind of work done during most of life. DO NOT use retired)		
Hygien other then the	12 4 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's	Ca Name (First, Middle, Maide	rpentry n Sumame)
nd 2 should be filed within hith and Mental Hygiene. 27 le marked other then "r treumatic event, Items To Be Comple		argaret Sny	der or Town, State, Zip Code)
and 2 s ealth an m 27 le r ner treur		orner RD Mi	11ington MD 21651
Pages 1 and of He	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cem.	Date 20c. 1	Location · City or Town, State
permit. Pages t and 2 Department of Health a Importent: If item 27 it eny Injury or other tree			Newnam Funeral Hongton, MD 21651
403.00	23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cannot be shock, or heart failure. List only one cause on each line.	SS St M1111 ardiac or respiratory arrest,	Approximate Interval Between Onset and Death
Pnysician /Medical	Immediate Cause (Final disease or condition resulting in death) a		Zyears
Examiner	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):		
executed in and ial-transit	Sequentially is continued at the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
cate be exphysician and the burial	d		
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Re Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year
res that the signed by the detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		ouse contribute to the cause of death?
The law requires the law requires the law seen signs page 2 should be completed by	peptic ulcer disease	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
icien: Th	25. Was case referred to medical 26. Place 0	1 ☐ Yes 2 ☑ ↑ of Death (Check only one)	lo 1 □ Yes 2 □ No
hyeicie his cert I direct		sing Home 5 Residence	
ding P. After t	27. Manner of Death 1	28d. Describe how in	ury occurred
tel or Attending Phy rs after death. ed in by the funeral d	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
he Hospitel n 24 hours and the Funerel pletely filled	29a. Certifier (Check only one) 1 **Descripting Physician: To the best of my knowledge, death occurred at the time, date and 2 **Description on the death occurred at the time, date and and manner stated.	place, and due to the cause n occurred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the within 7 To the comple	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
			8.22. 2005
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc S. Ballas 8901 Wisconson Ave, Re	thesele, M	0, 20889
State Registra	31. Date filed (Month, Day, Year) AUG 2 3 2005		

			1 - For State Registrar	State of N	Maryland / De <i>C</i>	partment o			nd Me		ene g. Na 2 0 0	5	289	938
	Physic		1. Decedent's Name (First, Middle, Las	t)					2	2. Date of Death			3. Time o	
	/Medi		Grace DiGiovanni							August	16 200!	ear O	9:15	Mg ö
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, To					4c. County of			
			Carroll Lutheran 5. Social Security Number 6. Se		dealth Car			nster			Carro			
П	Funeral Director			M 2 1 1 1	73 Yrs		ays		Min.	Date of Birth Month, Day, August	Year) 1021	. Birthpla Counti		_
	D		Usual Residence of Decedent							nugust	24 1931		M	<u> </u>
	anylar show	_	10a. State 10b. County		10c. City, Town or	Location						10	d. Inside C	ity Limits
	8a-1	Director	MD Carro	11	West	ninster							1 🖂 Yes	2 □ No
	with t		10e. Street and Number 200 St. Luke Ci:	ral o		10f. Zip Co		•		10	g. Citizen of Wha	at Count	y?	
	eath	Funeral	11. Marital Status	12. Was Deceden	t Ever in II S		2115		.0.(0		USA			
(0	r Hen	Fun	1 Never Married 2 Married	Armed Forces	?	 Was Decedent If Yes, specify 	Cuban,	, Mexican, I	Puerto Ric	can, etc.)	14. Race - Black, 1	America White, et	n Indian, ic.	
99	rel', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	_	1 ☐ Yes 2🎛	No	Specify:			Specify:	Whit	æ	
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an	d be annual ced o	o Be					'	B. Mothers	s Name (F	First, Middle, Ma	uden Sumame)			
Maryland	should Ind Meni	^L	John DiGiovanni 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	iling Address (S)	treet an			Eunno Route Number (City or Town, Sta	to Zin C	anda l :	
	and 2 saith a n 27 is er trau		Edward Buell/son			20 Campu							000)	
altimore,	- ± 2 ±		20a. Method of Disposition		20b. Place of Dis	position (Name of	of r nlace)	.,	Date		oc. Location - City		n, State	
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause ne cause on each	d the death. Do not a line.	inter the mode of	f dying,	such as ca	ardiac or re	espiratory arres	t,	1/	pproximate	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	End	toge	0	2me	っける				Onset and D つ よるv	Death C
	/Medical Examiner			Due to (or a	s a consequence of):)						,	-/	
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9 XO	eath certific attending p	Mec	IF FEMALE:	0-16										
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o.	that the de led by the detached	ysic	1 ☐ Yes 2 [2 No 9 ☐ Unknown	9 Unknown	it time or death	Other (specify	y)						-, .	oui
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Records,	taw re as bec 2 sho	Completed								24a. Wasan	24b. Were	autopsy	findings a	vailable
ř	The ta	Com							_	autopsy performed	prior death	to comp	letion of ca □ No	use of
Vital	ilcien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				2	6. Place of	Death (C	1 ☐ Yes 2 Theck only one)	110			
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		ertification:	27. May r of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury		Injury at Work?			. Describe how	injury occurred			
DIVISION	tten deatl ttor: the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of In	jury - At home, farm, s			s 2□No		[======== (O4====				
2	after datter datter de la Direct	erti	4 Homicide determined	building, e	ic. (Specify)	treet, ractory, on	ice		281.	City or Town, S	t and Number or itate)	'Hural H	oute Numb	Θ <i>r</i> ,
	e Hospitel or A: 124 hours after o E Funerel Direct letely filled in by	alC	29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge, de	ith occurred at th	e time,	date and p	lace, and	due to the caus	e(s) and manner	as state	nd .	
	the Hin 24 the Fu	ledical	(Check only 2 Medical Examir one)	ner: On the basis of and manner st	it examination and/or	nvestigation, in π	ny opini	ion, death o	occurred a	it the time, date	and place, and	due to th	e cause(s)	
	To the h within 2- To the f complete	Σ	29b. Signature and title of certifier	W Ma	2	29c. Lic		umber 5990	13	29d.	Date signed (Mo	onth, Day	v, Year)	
	WIL		X	- Jan	ME			_3 -(-(-)	1	transt	17.	2005	À
	1	-	30. Name and address of person who co	295 SPV		Print)	57	اسا	Stom	ineel	Min	7115	2	
	Stat	e	31. Date filed (Month, Day, Year)		ar's Signature	>01/1 >		•		11) 4	1,100	-11)		
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State

Registrar

egistrar's Signature

^{"2} 2005

State of Maryland / Department of Health and Mental Hygiene 2005 28940 1 - For State Registras Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year Edwin George Burnett 35 11:12 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth NOV. 27, 1930 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 141 22 4588 74 New Jersey Director Usual Residence of Decedent with the Maryland Show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28a-f shov the Medical Examiner must be notified at Director WV 1 ☐ Yes 2 ▼ No Morgan Great Cacapon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2862 Detour Road 25422 U.S.A. Funeral death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heatth and Mental Hygiene. Internet, or Ite marked other than "neturel; or Ite nry or othar treumetic event, the Medical Engine any or othar treumetic event, the Medical Engine. 1♥Pes 2□No If Yes, Give Year or Dates: 1970~ 99 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Non-commissioned officer U.S. Army 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Burnett Frances Cronk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Mary Burnett 2862 Detour Road, Great Cacapon, WV 25422 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 9/2/2005 Hagerstown, MD Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Helsley-Johnson Funeral Home, Inc. M00522 95 Union St., Berkeley Springs, WV 25411-1855 23a. Part 1. Enforch disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC /Medical Due to (or as a consequence of): Examiner HEMORRHAGE CEREBRAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de-th? page 2 should be FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ≥ nknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No репоrmed? 1 Yes 2 No Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28c. Injury at Work? after death. I Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 0006/410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 , md East 31. Date filed (Month, Day, Year) 32. agistrar's Signature State SEP 0 2 2005 Registrar

		•		Department of Health and N Certificate of Death	Mental Hygiene	211115 28ULL
	Physicia	an	Decedent's Name (First, Middle, Last) VELVE A BELKINDAS		2. Date of Death Month Da AUGUST 11,	y Year 2005 3. Time of Death 6:30 P M
	/Medic Examin	aı -	VELVE A. BELKINDAS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	. County of Death
	ZXXIIII		MANOR CARE HEALTH SERVICES	BETHESDA	Me	ONTGOMERY
	Funeral Director		5. Social Security Number 6. Sex 1 № 1	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) 921 LITHUANIA
	ъ	- 1	Usual Residence of Decedent		0211(* 10, 1	
	ahow abow	jo .	10a. State 10b. County 10c. City, Tow			10d. Inside City Limits 1X Yes 2 ☐ No
	r 28a-f	0	MARYLAND MONTGOMERY ROCKVII	10f. Zip Code	10g. Cit	tizen of What Country?
	th with	aiD	14401 TRAVILLE GARDEN CIRCLE, APT.	4144 20850	U.	S.A.
	tams	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	urs aft	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WHITE
2-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	sing 16b. K	find of Business/Industry
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural" or Itams 23a or 28a-f show the Meulcal Evantrer must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Nife. DO NOT use retired)	П.	S. GOVERNMENT
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Maryland	should be ind Menta s marked umatic ev		AARON BELKINDAS	RIVA	MA	
Mar	12 sho h and 7 is my traum	144	, , , ,	. Mailing Address (Street and Number or Rui 206 KINGS BRIDGE WAY		
	Health Health tam 27 other tr		20a Method of Disposition 20b. Place of	Disposition (Name of		ocation - City or Town, State
OE E	Pages nent of int: ff its		1 Ku Burial 2 □ Cremation 3 □ Removal from State	y, crematory or other place) N MEM - GARDENS 08/14	4/2005 OLN	EY, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygieno. Important: If than 27 is marked other than "natural" or Itams 28a or 28a-f show any injury or other traumatic event. It Medical Examiner must be notified at once.		21. Signature of Funeral Service-Licenses	22. Name and Address of Facility EDWARD SAGEL FUNER 1091 ROCKVILLE PIK	AL DIRECTIO E, ROCKVILL	N, INC. E, MD 20852
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	hapic Stroke		Onset and Death
	/Medical Examiner		Due to (or as a consequence	eneron.		
		ner	if any, leading to immediate Due to (or as a consequence			
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	nove thombosis	am	,
8760,	cate be executed physician and the burial-transit	aiE	Rainsent	Cespison P	neumenit,	
9	tificate g phys	ledic	u	0		
Вох	death certificate be executed e attending physician and id for use as the burial-transit	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death			23d. Date of delivery Month Day Year
0		Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
٥.	The law requires that the tee has been signed by thoage 2 should be detached.	by Ph	Part II. Dther significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords	w require been sig should b	ted t			1 ☐ Yes 2	No 3 Probably 4 Unknown
Vital Records,	e law r has be ge 2 sh	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a		e Cor	25. Was case referred to medical	00 Pl (P	1 ☐ Yes 2 ☐ No	
N N	S S S	To Be	examiner? 1 Yes 250 No Hospital: 1 Inpatient 2 ER/Ou	Othor	ome 5 Residence	6 □Other (Specify)
n of	ding Ph h. After thi funeral			Fime of 28c. Injury at Work?	28d. Describe how inju	ry occurred
Division	Attanding r death. actor: After by the fune	icati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Tyes 2 No	28f Location (Street a	nd Number or Rural Route Number,
DIX	after Dirac	Certification:	4 Homicide determined building, etc. (Specify)	inii, sireet, ractory, onice	City or Town, State	e)
	To the Hospital or Attanding Ph within 24 hours after death To the Funeral Diractor. After th completely filled in by the funeral	edical C	29a. Certifier Certifying Physician: To the best of my knowledg	a, death occurred at the time, date and place,	, and due to the cause(s	s) and manner as stated.
	tha H	Medi	one) \ and manner stated.			
	T W T		1 typhods /M	D 5369	1	28-12-2005
•	V		30. Nama and address of person who completed cause of death (Item 23a)	(Type, Print)	21 B	eliserdy, Mo
			31. Date filed (Month, Day, Year) 38. Registrar's Signature	w Devace	500/	20817
	Sta Registr		AUG 19 2005	29c. License number 53 69 (Type, Print) W Devocory		

,	1	Please		i nt in Black Ir faryland / Dep <i>Ce</i>		lealth and M	ental Hyg		28942
Physician /Medica		1. Decedent's Name (First, Middle, I	CULP		4h City Tours	or Location of Death	2. Date of Dear Month AUGUST	Day Year	05 7:17 A ^M
Examiner Funeral Director		40.24 HANSON RC 5. Social Security Number 6 429-30-6775	DAD	ge (In yrs. last birthday 82 Yrs.	WHITE		8. Date of Birth (Month, Day, JAN - 2	CHAI	aun RLES irthplace (State or Foreign Country) RKANSAS
e Maryland		Usuel Residence of Decedent 10a. State 10b. County MARYLAND CHAF	RLES	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2√No
1215-0036 within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28e-f show he Modeal Examinat must be netitied at	icial Disc	10e. Street and Number 4024 HANSON RO	12. Was Deceden	t Ever in U.S. 13.	10f. Zip Code 2069 Was Decedent of H	5 Hispanic Origin? (Spe an, Mexican, Puerto F	d d		nerican Indian,
hours after or item	מת הא ו תו	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	If Yes, Give Year or Dates]No :	If Yes, specify Cubing 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Specify:		Black, What Specify:	WHITE
O 8 5 5 6		(Specify only highest of Elementary/Secondary (0-12) 1 1 17. Father's Name (First, Middle, La	grade completed) College (1-4or	(Giv.	e kind of work done DO NOT use retired IEMAKER	during most of workir	ng	OWN HO	,
Maryland 4 2 should be flik th and Mental Hy 17 le marked oth treumatic event	בֿ ב	JAMES BREEM 19a. Informant's Name/Relationship		19b. Mail	ing Address (Street	MURTA	HAYNES		, Zip Code)
Page Page ment of ant: If arry or	_	TERRI CULP—DAL 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice	□Removal from State cify) ME	20b. Place of Disp cemetery, cre TROPOLIT	ematory or other place	CO) ATORY 9-	ate	AINS MD 20c. Location - City of ALEXAND	or Town, State
Balt permit. Depart Import any injury	-	23a. Part1. Ther the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplication that cause by one auch	ed the death. Do a er line.	RAYMOND TAPLATA nter the mode of dyir	FUNERAL MARYLA ng, such as cardiac o	r respiratory arr		Approximate Interval Between Onset and Death
Medical be executed cian and build-transit	מוראמ	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	S a consequence of): S a consequence of): S a consequence of):	CARDO	myolate	17		
death cert death cert death cert death cert death cert death	I yalcıdı izinine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	4		23d. Date of d Month	elivery Day Year
S 8 8 8	2	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown
The law ate has t		25. Was case referred to medical						y prior to med? death' 2⊠No 1 □ Ye	autopsy findings available completion of cause of s
ding Physical di	2	vascus referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could no	t be	jury 28b. Time lay Year) Injury	of 28c. Injur World 1	ry at rk? Yes 2 □ No	ne 5 Reside	ence 6 Other (Sp ow injury occurred	
Division o To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	al Certifi	4 Homicide determine	Physicien: To the bes	njury - At home, farm, s etc. (Specify) st of my knowledge, dea	th occurred at the time	me, date and place, a	City or Town	ause(s) and manner	as stated.
To the Hosp within 24 hou To the Funer completely file	Medic	(Check only 2 Medical Exone) 29b. Signature and title of certifier	ambdr: On the basis and manner s	of examination and/or i	29c. Licens	ppinion, death occurre	ed at the time, d	ate and place, and di	ue to the cause(s)
5		30. Name and address of person of	no completed cause of	death (Nem 23a) (Type	Print) Ropo	# 304	warp	of mo	20602
State Registra		31. Date filed (Month, Day, Year) SEP 0 6	32. Anglis	trar's Signature	parte				,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 28943 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Month Linda Martin Cruickshank 16, Aug. 5:39 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country)

Physician

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other treumetic event, the Medical Examiner rough be notified at once.

Baltimore, Maryland 21215-0036

Funeral Director

Examiner	
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical Examiner

5//-/0-8	806	-X	53	115.				Apr.	1. 1	952 1	Washingto	on. I
Usual Residence												
10a. State	10b. County Princ	e Georges		ity, Town or L ttsvil							10d. Inside (City Limits
10e. Street and No	umber				10f. Zi	p Code			10g. Cit	izen of Wha	it Country?	
6500 Pa	rkway C	ourt				20782			U.	S. A.	,	
11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.	Was Dece	dent of His	panic Origin? Mexican, Pur	(Specify Yes or erto Rican, etc.)	No-	14. Race -	American Indian, White, etc.	
	rried 25 Marr 4 Divorced	ied 1 ☐ Yes If Yes, Gir Year or D	/e		1 ☐ Yes		Specify:	,		Specify:	Black	
(Spe	15. Decedent ecify only highes	's Education st grade completed)		/Give	edent's Usu s kind of wo DO NOT u	ork done di	ion uring most of w	vorking	16b. K	ind of Busin	ess/Industry	
Elementary/Sec	condary (0-12)	College (I-4or 5+)				chnicia	n	GO	vernne	ent.	
17. Father's Name	(First, Middle,	Last)		<u> </u>	ayro.			lame (First, Mide				
Napoleo	n Marti	n						. Vaughn				
19a. Informant's N	Name/Relations	hip (Type, Print)		19b. Maili	ing Addres	s (Street ar	nd Number or	Rural Route Nur	nber, City o	r Town, Sta	te, Zip Code)	
Demita	James -	daughter					l'errace	e, Upper	Marl	boro,	MD 2077	4
20a. Method of Dis		3 Removal from	State	Place of Dispo cemetery, cre	matory or	other place	1 -	Date			y or Town, State	
21. Signature of iF		**	Lir	coln M	em. I	Park	of Facility T	22-05	Sul	tland	, MD	
1 Gudi	4KG	chrise						Sell Fun No., Te			P.A. , MD 2074	48
231. Part1. Enter shock, or he Immediate Cause disease or conditi resulting in death)	(Final	complications that conly one cause on e	69725L	Ć	ter the mod	de of dying,	such as cardi	iac or respiratory	arrest,		Approxima Interval Be Onset and	etween
Sequentially list of if any, leading to icause. Enter Und Cause (Disease of that initiated event resulting in death)	IS	с	or as a consector as	J-4] quence of):	ic (2/00	n Ca	'u CCr				
IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months?		irth 2 Feta ant at time of c	Ideath 3	□Ectopic p □ Other (sp				-	23d. Date of Month	delivery Day	Year
Part II. Other sign	ificant conditio	ns contributing to de	eath but not res	ulting in the u	inderlying o	ause given	in Part I.			se contribut	e to the cause of	death?
								24a. Wi au pe 1 \(\text{Yes}	topsy rformed?	prior	autopsy findings to completion of	available
25. Was case refe examiner?	erred to medical						26. Place of De	eath (Check only				
Yes 2] No	Hospital: 1 □ I	npatient 2	ER/Outpatier	nt 3/2 DC	Other	4 Nursing	Home 5 Re	sidence 6	3 ☐ Other (S	Specify)	
27. Manner of Dea 1 Natural 2 Accident	ith 5 🗆 Pending investig	d	of Injury h, Day Year)	28b. Time of Injury	f A	28c. Injury a Work?	it	28d. Describ	e how injur	y occurred		-

State Registrar

31. Date filed (Month, Day, Year) AUG 1 9 2005

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

Stephen Smith, MD, 7600 Carroll Avenue, Takoma Park, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 28944 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2:00 A AUG. 18, 2005 CHAMBLEE **JAMES** Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral №** M 2□ F NORTH CAROLINA DEC. 2, 1938 Director 66 134-28-0241 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 XYes 2 □ No Director COLUMBIA MD. HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 U.S.A. 21044 10069 WINDSTREAM DR.#3 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2x No Specify: þ 3 Widowed 4 Divorced WHITE leted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Compl Elementary/Secondary (0-12) College (1-4or 5+) perrit. Pages 1 and 2 should be filed will Depurtment of Health and Mental Hyglen. Important: If item 27 is marked other the any injury or other traumatic event, Item 2006. FED. GOV'T. COMPUTER SCIENTIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTON CHAMBLEE SR. ANN 2 **JAMES** A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10069 WINDSTREAM DR. #3, COLUMBIA, MD. 21044 EILEEN CHAMBLEE/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CHAMBERS CREMATORY | 8-20-2005 RIVERDALE, MD. 21. Signature of Funeral Service Livensee 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MINUTES ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) **Examiner** YRS. CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) the attending physician pe Physician/Medical the use as t IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an INSULIN DEPENDENT DIABETES autopsy performed? (es 2 \sum No 2 No 1X Yes 1 X Yes GALLSTONES Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Xinpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of After Certification: 5 Pending Injury 1 Xlatural 1 Yes 2 No death. investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier han. m AUG. 18, 2005 D35217

10

Box 68760

P.O.

State Registrar

31. Date filed (Month, Day, Year)

DAVID

JACKSON, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygien 2005 28945 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Daniel Edward Clarke, Jr. /Medical August 2005 9:30A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital <u>Montgomery</u> 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 X M 2 ☐ F Months Hours Director 579-10-7358 86 Aug 07, 1919 Washington, DC Usual Residence of Decedent the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: if Item 27 is marked other than "naturat", or Items 23a or 28a-f show ury or other traumatic event, it a Medical Examiliar investive inclination. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Silver Spring Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 902 Balmoral Dr 20903 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel E. Clarke, Sr. Alwine Baurman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Antonia C. Selinsky/Daughter</u> 117 Buttercup Dr. Cranberry Township, PA 16066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of important: If any njury or once * 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Aug 22, 2005 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee Na 11800 New Hampshire Ave, Silver Spring, MD 20904 200 23a. Part1. Enter the disk se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart below. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Fra se (Final disease or condition resulting in death) **Physician** Metastatic Bladder Cancer year /Medical Due to (or as a consequence of). **Examiner** Coronary Artery Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Colon Cancer years that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 20 No certificate 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death, investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funaral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and itle of certifier 29c. License number 29d, Date signed (Month, Day, Year)) aush 3. D50987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 83819 Gailhersburg mozog 2 31. Date filed (Month, Day, Year) 32 Registrar's Signature 22 AUG Registrar

State of Maryland / Department of Health and Mental Hygieney 28946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gentry Comer 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hagerstown Washington County Washington 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday) If Unde Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 168-14-2651 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene.

any Injury or other than the marked other than "navier." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Adams effeville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17222 6375 U.S. A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturina 8 Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Washington Lomer Mae Khodes Long (500766 P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) K. Comer 17404 roal York PA 2937 Cedar Rd Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery -97-02 Hanover, ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Wetzel Funeral Home, Inc. 549 Curlisle St. Hander, IA 17331 23a. Part1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events been signed by the attending physiclen and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? NSUFFICIENCY 1 ☐ Yes 2**Z** No 3 Probably 4 □Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 2□ No 1 Yes 1 Yes Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only of Hospital: 1 _ Inpatient examiner? 1 🗌 Yes ER/Outpatient 3 DOA Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending death. 1 Tyes 2 🗆 No 2 Accident investigation Director: 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PA 05003933-6 address of persor pleted cause of death (Item 23a) (Type, Print) 4 FIELD TRL 31. Date filed (Month, Day, Year) State AUG 1 9 2005 Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryland / Depa Registrar Cent	rtment of Health and Metificate of Death		ene g. No 2005	28947
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) NORA BELLE CRUSH	ONG.	2. Date of Death Month	Day Year OS	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) CARROLL HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	4c. County of Death CARROLL 9. Birthpl	lace (State or Foreign
	Funeral Director		220-26-5730 1□ M 2⊠ F 77 Yrs. Usual Residence of Decedent		(Month, Day, 5 / 1 4 / 1 9	928 MARY	LAND
	ne Marylau 8a-f show	Director	10a. State 10b. County 10c. City, Town or Loc MD CARROLL WESTMI	NSTER			0d. Inside City Limits 1 Yes 2 □ No
	ath with the 23e or 2	ral Dir	10e. Street and Number 102 TIMBER RIDGE DR., APT. 306	10f. Zip Code 21157		USA 14. Race - Americ	4
036	urs after de el', or Items Exeminer	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 25 No If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F Yes 2 No Specify:	Rican, etc.)	Black, White, of Specify: WHI	etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23e or 28e-f show or other treumatic event, the Medical Experiment must be usuallied at	Completed	(Specify only highest grade completed) (Give kind if the completed) (Give	ent's Usual Occupation kind of work done during most of workin DO NOT use retired)	ng	16b. Kind of Business/Ind	•
nd 2	be filed v tal Hygie d other t event, In	Be Co	17. Father's Name (First, Middle, Last)	ESTATE BROKER 18. Mother's Name	(First, Middle, M		TE
Maryland	2 should the and Ment is marked eumatic e	To		g Address (Street and Number or Rura	A BELLE I Route Number,		Code)
	1 and 2 Health a lem 27 ls		BRENDA L. GREEN - DAUGHTER 1920 20a. Method of Disposition 20b. Place of Dispos	sition (Name of		NSTER, MD	
altimore,	Part in		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State *4 □ Donation 5 □ Other (Specify) EVERGREEN	MEM • GARDENS	0/05 F	INKSBURG,	MD.
Ba	permit. Departr Importe any inji		N - 1/9/2K	Name and Address of Facility LET			
The state of the s	Physician /Medical Examiner	Examiner	23a. Part 1. Enfact e disease, or complications that caused the death. Do not enter shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequential visit conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	stream of dying, such as cardiac of the mode of dying, such as cardiac of the such as cardi	R R	t lower	Approximate Interval Between Onset and Death
ox 68760,	leath certificate be executed attending physician and I for use as the burial-transit	dicai	IF FEMALE: 23b. Was decedent pregnant	voscular	dise	23d. Date of delive	l wes.
.O. Box	that the death led by the atter detached for t	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Ectopic pregnancy Other (specify)		Month	Day Year
rds, P	The law requires that the death certifi tte has been signed by the attending I oage 2 should be detached for use as	by	Part II. Other significant conditions commonly to death but not resulting in the dis	iderlying cause given in Part I.	23e. Did tob	acco use contribute to the	ably 4 Unknown
al Records,		Completed			24a. Was an autopsy perform	y prior to con	psy findings available inpletion of cause of 2 No
of Vital	ding Physician: Th n. Affer this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death Other: 4 Nursing Hon	****	e) nce 6 □Other <i>(Specif</i> y	1)
Division o	ding h. After fune	Certification;	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Work? M 1 ☐ Yes 2 ☐ No		w injury occurred	
DIVI	e at te	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Str City or Town,	reet and Number or Rura , State)	! Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death 2 **Medical Examiner: On the basis of examination and/or invariant and manner stated.				
)	Markin Solution	Σ	29b. Signature and title of certifier	29c. License number	. 29	ed. Date signed (Month, I	Say, Year)
	0,0		30. Name and address of person who completed cause of death (Item 23a) (Type, FREIS! 295	D 38915 STONER AU	e u	PESTHINS	TER MD 21157
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 9 2005				

OK to accept 23a PART I PER DIAMA BANBONE

Willia 05-055 crn		ley	Creeger, Jr. Please T 1- State Registrar	ype or Print in E State of Marylan	d / Depart		lealth and N	Mental Hyg	_		28948
	Physicia	20	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	Yeer	3. Time of Death
	/Medic	al	William Stanley CA 4a. Facility Name (If not institution, give s		4	h City Town o	r Location of Death	August	18, 20		12:54 A ^M
	Examin	er	Ebenezer Church Road ne			Rising			Ced		
	Funeral Director		5. Social Security Number 213-19-3782 Usuaf Residence of Decedent	7. Age (In yrs. 3:	A.	f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 1	Year)	9. Birth Cou	pplace (State or Foreign intry) MD
	within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28s-f show the Modical Exercitors Let notified at	ctor	10a. State 10b. County MD Cecil		y, Town or Locat Sing Sun				-		10d. fnside City Limits 1 ☐ Yes 2 No
	with the general sections	Funeral Director	10e. Street and Number	, d		10f. Zip Code 21911	ı	1	0g. Citizen of W	hat Cou	intry?
	death me 23	eral	932 Telegraph Roc	2. Was Decedent Ever in U.	.S. 13. Wa		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-			ican Indian,
9800	ours atter or ites	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 🗆	Yes 2☐XNo	Specify:		Specify:		te
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel, or iteme 23s or 28s-f show any injury or other traumatic avent, the Medical Exercites trust be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give kin	NOT use retired	during most of work	king	16b. Kind of Bus		,
and 2	lbe filed valued Hygie	Be	17. Father's Name (First, Middle, Last) William Stanley (Than sale Ch	rwur	iei	18. Mother's Nam	ne (First, Middle, i			ure
Ž.	should nd Mei mark imatic	င္	19a. Informant's Name/Refationship (Type		19b. Mailing	Address (Street	and Number or Ru		, City or Town,	State, Z	ip Code)
N.	elth are 27 to 27 to er trau		Monica Creeger/W	be	932	Telegra	ph Road,	Rising.	Sun, MD	21	911
Baltimore,	Pages 1 and the part of the pa		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □R: 4 □ Donation 5 □ Other (Specify)	BIHOVAL HORRI STATE	Place of Dispositi Semetery, cremat OOKVIEW		1	Date 2 - 2 0 0 5	20c. Location - 0	80	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License		22. N	ame and Addre	en Street	T. Foard	Funera	2 Ho	me., P.A. 21911
	Physician /Medical Examiner		23á. Part. Enter the disease, of compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause/on each line.	SULU		ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
Box 68760,	tificate be executed ig physicien and as the burial-transit	dicai Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq							
(A) O. Box 6	death cer e attendin id tor use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	il death 3 ⊟Ed	ctopic pregnancy ther (specify)	у		23d. Date Mor		very Day Year
ds, P.	uires that th signed by Id be detac		Part II. Other significant conditions con	tributing to death but not res	ulting in the unde	erlying cause giv	ven in Part I.				the cause of death?
Recor	ding Physicien; The law requires that the h. h. Aftar this certificate has been signed by th tuneral director, page 2 should be detache	Completed						24a. Was a autops perform	med? d	Vere au rior to d eath?	topsy findings available ompletion of cause of
/ital	cian; artitica actor, p	Bec	25. Was case referred to medical examiner?					th (Check only or			
of C	Physic this co	ို	1 X Yes 2 No Path		ER/Outpatient 28b. Time of	3L DOA		ome 5 Resid			at scene
$\mathbb{R}_{\mathbb{R}}$ Division of Vital Record	To the Hospital or Attending Physicien; within 24 hours after death. To the Funeral Director: After this certifics completely lilled in by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 8-18-05 28e. Place of Injury - At h building, etc. (Special	Injury 00:43 A		rk? Yes 2 🔀 No	Left ro	devivin	5 m	THE POLICE HED
Ō	oital or urs att rai Dir lied in	Cer		V	oad			South of MC	rady IZD	RS	ng Sun, MD
	Hosp 24 hou Fune stely til	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death o ation and/or inves	ccurred at the ti stigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and mad ate and place, a	nner as ind due	stated. to the cause(s)
_	To the within. To the comple	Me	29b. Signature and the of certifies	Ma		29c. Licens		1	9d. Date signed		-
	47		30. Name and address of person who co	peted cause of death (Iter	n 23a) (Type, Pr		.C.M.E.		August	18,	2005
	/		S. 2. HOG.	AN	111 Pe		et, Balti	more, Ma	ryland	2120)1
	Sta , Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 2 2005	32. Registrar's Sign	ature						

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CHERRY Year Physician BABY GIRL AUGUST 2:56 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Funeral 1 □ M 2 XF 48 48 Months Days Hours Yrs. Director AUGUST 11,2005 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 □ No MARYLAND BALTIMORE CIT 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 1105 BONSAL 238 STREET 21224 Funeral Iteme 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: if Item 27 is marked other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NEWBORN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MERION CHERRY ALISON EDWARD DIANE BARABASOZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is any injury or other traisonce. 1105 BONSAL STREET BALTIMORE MARYLAND 21224 ALISON DIANE BARABASOZ MOTHER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 0 CTOBER 7, 2005 cometary, cramatory or other place)
NEW CATHEDRAL

CEMETARY Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Facility ST. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOSPITAL AGNES De adviar Long GALTIMORE, MARYLAND per Sue Ly 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AT 22 WEEKS OF GESTATION IMMATURITY disease or condition resulting in death) 2 hours 48 Minus /Medical Due to (or as a consequence of): Examiner INCOMPETENT CERVIX Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9☐ Unknown 9 🗆 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 X No 1 ☐ Yes 2 ☐ No 1 Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification; Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No investigation NONE 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide the Hospital pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 11, 2005 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 900 SOUTH CATON AVENUE Siew-Jyu Saint Agnes Hospital Wong MD BALTIMORE MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

BABY

		T – For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artmen <i>tificati</i>	t of He	ealth a	and Me	ental Hy	giene Reg. No.	005	28950
Physic	an	1. Decedent's Name (First, Middle								2. Date of Dea Month	Day	Year	3. Time of Death
/Medi	cal	KATHRYN D.	CUMMIN			4b. Cibe	Tour or	Location of	of Doath	AUGUS		2005 nty of Death	6:30a [™]
Examir	1er	4a. Fecility Name (If not institution 13063 Kentmon	-					vvi1				nt	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		1 Year	If Under Hours		8. Date of Birt (Month, Da)	1		place (State or Foreign
Director		286-01-6245	1 □ M 21X F	90	Yrs.	Months	Days	Hours		Mar 18		5 Ohio	
and	1	Usuel Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				·		1	Od. Inside City Limits
Manyli f eho	ō	MD Ken	+	K	ennedy	/v/il1							1 ☐ Yes 2 ☑ No
r 28e	irec	10e. Street and Number		100	cimea	10f. Zip					10g. Citizen	of What Cour	ntry?
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s afte	by Fu	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	If Yes G	2 ⊠ No ive Dates:		1 □ Yes	2 / No	Specify:			Spe	city: Wh	ite
stural		15. Deceden	t's Education		16a. Deced	ient's Usua	al Occupa	tion			16b. Kind o	f Business/Inc	dustry
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od 2 s lith an 127 ls i		David J. Cur		(son)									21645 Lle, MD.
item 27		20a. Method of Disposition		20b. I	Place of Dispo	sition (Nan	ne of			ete		on - City or To	
Pages nent of 1 ont: If its		1 ☐ Burial 2 🛣 Cremation '4 ☐ Donation 5 ☐ Other (S		State	ent Cr				8/28	/05	Smyrn	a, DE	Ε.
permit. Pages 1 Department of 1 Importent: If ite any Injury or ot once.		21. Signature of Fineral Service	Lidensee			. Name an				·	£ C+-	~ h ~ m	T Cabaca
1 88 E 5 8				M0051	0 1	18 W	est	Cro	ss S	t. Ga	lena,	MD.	L. Schaec 21635
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Physician		Immediate Cause (Final disease or condition resulting in death)	a	Alzhei		dem	MIN						
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The law requires that the death certificate The law seen signed by the attending phys page 2 should be detached for use as the	/Me	IF FEMALE:	23c. If ves. o	utcome of pregn	ancv						23d	Date of delive	200
eath cattern atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	aldeath 3 [Ectopic pr Other (sp					250.	Month	Day Year
the day the	hysi	9 Unknown	9□ Unk	nown									
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law re las be	Completed									24a. Was autop	sy	prior to co.	psy findings available mpletion of cause of
VICAL INC. slclen: The law s certificate has t	Co									1 Yes	2 No	death? 1 ☐ Yes	2 🗆 No
VILC Ilclen certifi rector	Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only o			
5 £ 13 8	: To	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatier 28b. Time of		28c. Injury Work	4 🗆 🖂	ursing Hom	18d. Describe h		Other (Specificurred	у)
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Atternation of the part of the	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place	e of Injury - At h	nome, farm, str	eet, factor	y, office		2	8f. Location (S City or Tov	Street and Nu	mber or Rura	al Route Number,
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edicai	(Check only 2 Medical	ng Physician: To the Exeminer: On the	basis of examin									
thin 2 the 3 the	Med	29b. Signature and title of certifie		nner stated.		290	c. License	number			29d. Date, sig	ned <i>(Month</i> ,	Day, Year)
¥ ₹ 8		band	5 AN	LOSAN			_		423		8/2	7/05	
		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type.	Print)	,,,,,	<i>V</i>	<u>سر</u> ۔ ,	•	-/-	.1	21620
6			de la Ro				Chu	rch	Hi11	Rd.	Chest	ertow	m, MD.
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Regist	rar	JLF U	1 2005	Elem	St K								

DHMH 17 Rev 1/2001

	4	State of Maryland / Departmen		-	_	
		1 - State Certificate	e of Death	R	eg. No.2 1 1 5	28951
Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
/Medic		GLADYS DELORES DIETZ		AUGUST		
Examin	er		Town, or Location of Deat	h	4c. County of Dea	ath
		GENESIS LA PLATA CENTER LA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	PLATA 1 Year If Under 24 Hrs.	8. Date of Birth		RI.ES
Funeral Director		176-01-1072 1□M 2XF 89 Yrs. Months	Days Hours Min.	(Month, Day SEPT . 8	, Year) C	rthplace (State or Foreign Country) NNSYLVANIA
D D		Usual Residence of Decedent		DBITTO	71313 116	
arylar	<u>.</u> .	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Ba-1	Scto	MARYLAND CHARLES LA PLATA				MYes 2 No
be filed within 72 hours after death with the Maryland the Hygiene. Hygiene. d other than "natural", or itema 23a or 28a-f ahow event, Ite Medical Examiner must be notilised at	Funeral Director	10e. Street and Number 10f. Zip		1	0g. Citizen of What C	Country?
eath Turi	erai		0646 Sent of Hispanic Origin? (S	specify Yes or No-	U . S . A . 14. Race - Am	encan Indian
fler d	표	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo	dent of Hispanic Origin? (S orly Cuban, Mexican, Puerl	to Rican, etc.)	Black, Wh	
arit, o	þ	3 ☐ Widowed XXDivorced If Yes, Give 1 ☐ Yes 3	2⊠ No Specify:		Specify:	WHITE
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partimore, vin permit. Pages 1 and 2 Department of Health a important: if item 27 it any injury or other tre pace.		20a. Method of Disposition 20b. Place of Disposition (Nan cametery, crematory or o	ne of	Date	20c. Location - City o	r Town, State
Pages nent of lint: if it,		1 ☐ Burial 2 XCremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) METROPOLITIAN CR	ı	-1-05	ALEXANDRI	T 7 V 7.
permit. Departminimporta any inju		21. Signature of Funeral Service Licensee MO0479 22. Name an	d Address of Facility			LA, VA
Depariming permi			ND FUNERAI ATA, MARYI		JE, P.A. 9646	
		23. Part1. Enter the disease, or complications that caused the death. Do not not ter the mod shock, or heart failure. List only no cause on each line.	e of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	1617-161	1756	1,515,	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):				
Examinei	_	Sequentially list conditions, b. b.				
√ b ± is	Examiner	fauly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1252 JC	Lines	71	
xecut and	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
te be executed ysiclan and le burial-transit	calE					
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at the	Physician/Med	9 LI UNKNOWN				
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alaw dash dash	npie			24a. Was a autops	y prior to	utopsy findings available completion of cause of
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th. Affe	tion	1 (∑Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No	255. 2555.125 (16	on injury document	
Attan deal actor	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory	r, office	28f. Location (St	reet and Number or F	Rural Route Number,
el or or or or or or or or or or or or or	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Towi	n, State)	
To the Hospitel or Attanding Physician: The law requires that the death certifical within 24 hours after death. To the Housra after death. To the Funarial Director: After this certificate has been signed by the attending phy completely filled in by the funarial director, page 2 should be detached for use as the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place	e, and due to the co	ause(s) and manner a	is stated.
the H hin 24 the F	Medical	and manner stated.				
To To	-	29b. Signature and title of certifier	: License number	2012	9d. Date signed (Mon	1 Jay, rear)
		The state of the s	7206		0/2//	7 ())
\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	WADW	15.231	~7 ML	50
Sta	ite	31. Date filed (Month, Day, Year) 32 Degistrar's Signature	V V I A	1	6 00	7.
Registr		SEP 0 6 2005 Decree St Species				

DHMH 17 Rev 1/2001

Amend Item State of Maryland / Department of Health and Mental Hygiene Dr., G848, 19/12/05dhb Death Reg. No. 95 28952 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DERIMER 2005 /Medical 4c. County of Death gility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner MSTERTOWN der 1 Year If Under 24 Hrs. Hospita 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠**M 2□F 30 9908 Director 217 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28e-f show other treumatic event. The Mudical Evertime in must be inclified at 1 Yes 3 No KENT Director MD ENNEDYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A SHALLCROSS RUZO 21645 WHARF death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1. Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify It Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hyglene. em 27 Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) NEWSPAPER EDITOR 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HAWKINS Be HARRY DERINGER MABEL ROBERTSON HURTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) t of Health ASHWORTH JUDY Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If any injury or once. HESAPEAKE CREMATIONS B 4 □ Donation 5 □ Other (Specify) 23/05 HESTER 22. Name and Address of F cility 21. Signature of Fugeral Service Licenses FUNERAL DIRECTOR 21620 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 205 GREEN MERCH WAY CHESTERTOWN MD Approximate Interval Between Onset and Death Immediate Cause (Final ARTORIOSCIENOSIS CAPPIONAFILLIAR DISETA Physician LEMAS disease or condition resulting in death) /Medical Examiner MULLITUS DIAGUTUT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 25 No 1 ☐ Yes or Attending Physicien: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ♣R/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: P 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 ho To the Fune completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/22/05 00057509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 WASHINGTON AVE, CHEAGETOWN, MP 21620 JAMET CACEY, MP 32. Registar's Signature 31. Date filed (Month, Da State 3 2005 Registrar

			1 - State of Mary		rtment of Hea tificate of De			ene 0 0	5 28953	٠
	Physicia /Medic		Decedent's Name (First, Middle, Last) Cora	Daugh	nerty		2. Date of Death Month	Day 1	Year 05 0235 A M	
	Examin		4a. Facility Name (If not institution, give street and number) Coastal Hospice at the Lake		ALISBURY			4c. County of		
	Funeral Director		5. Social Security Number 218-05-8732 G. Sex 7. Age (Ir 1 m 2	n yrs. last birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, 1 9/17/19	Year) 18	9. Birthplace (State or Foreign Country) Maryland	
	Maryland -f ehow ied al	tor		Salisbu					10d. Inside City Limits 1 ☐ Yes ② No	
	or 28e	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	nat Country?	
	ieath v	Funerai	322 Carey Ave. 11. Marital Status 12. Was Decedent Eve	r in U.S. 13. V	2180 Vas Decedent of Hispar Yes, specify Cuban, M	·	rify Yes or No-	USA 14. Race	- American Indian,	
036	ours after or Iter	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:			lexican, Puerto R	ican, etc.)	Black, Specify:	, White, etc. White	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or liems 23e or 28e-f ehow he Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	ent's Usual Occupation kind of work done durin OO NOT use retired)		9	6b. Kind of Busi		
d 21	filed w Hygier other th	Be Col	10	Homem		Mother's Name	(First, Middle, Ma		mestic	_
ylan	2 should be and Mental remarked or reumatic ever	To B	Louder Washington Brumbley			Bertha I	illian (Owens		
Mar	d 2 sho		19a. Informant's Name/Relationship (Type, Print) Jack Daugherty/son		g Address (Street and				2.17-2	ĺ
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparantent of Health and Mental Hygiene. Importants if item 27 is marked other than "neturel; or items 23e or 28e-f show any injury or other treumatic event, the Madical Examinational Legical anone.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	20b. Place of Dispos Springhil	Dividing I sition (Name of patory or other place) I Memory	8/20/	ite 20		city or Town, State	
Baltir	permit. P Departme Importen any injur		21. Signature of Funeral Service Licensee	- 1 H	Name and Address of Olloway Ful 01 Snow Hi	Facility	me Profe	ossiono.	l Association	-
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	r the mode of dying, su	uch as cardiac or	respiratory arres	cy, MD	Approximate Interval Between	T
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Onses Tourist and Tour	onsequence of):	cart Fa	e / we			Onset and Death Subsign 15	5
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Ć,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):				_		
8760,	cate be physicia s the bur	dicai	d							=
.O. Box 6	he death certific the attending p ched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of the first part of the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Month		
0_	requires that the d een signed by the hould be detached	ed by Ph	Part II. Other significant conditions contributing to death but n	ot resulting in the un	dertying cause given in	Part I.	23e. Did toba	\sim	oute to the cause of death? B Probably 4 Unknown	
l Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy performs	ed? de:	ere autopsy findings available for to completion of cause of ath?	
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of	ng Phys ter this neral dii	n: To	1 Ves No 1 Minpatient 27. Manner o Death 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of ear) Injury	28c. Injury at Work?	4 Nursing Hom	e 5∐ Residen 3d. Describe how			-
Division	or Attending after death. Director: After in by the fune	ertification:	Accident investigation Suicide 6 Could not be		M 1 ☐ Yes	2 No	of Location (Stre	et and Number	or Rural Route Number,	-
<u>≥</u>	rs after al Dire	Certi	4 Homicide determined building, etc. (8	Specify)	ot, radioly, difficult		City or Town,			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Cartifying Physician: To the best of models of examiner: On the basis of examiner and manner states.	agamation and/or inv	estigation, in my opinio	n, death occurre	d at the time, dat	e and place, an	nd due to the cause(s)	
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Gin,	29c. License nu	mber 27	2/2		(Month, Day, Year)	
	T.		30. Name and address of person who completed cause of death	h (Item 23a) (Type, F	Print)	By Do	2	1)	7-05 MN 21862	,
	Sta	te	31. Date filed (Month, Day, Year) 3 2005 32. Poistrar's	Signature	e p.o., ,	130x //3	2 20	3/15h)	-
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3 tha Maryland 40 72 hours after d 2 should be fi.
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P.O. Box 68760

Division of Vital Records,

Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 28954 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2330°M Dean Deuberry 2005 ust 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REGIONAL Medical SALISBUN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1**X**0 M 2□ F 3/29/1936 Indiana 69 Director 304-36-5809 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Wicomico Parsonsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 32776 Old Ocean City Rd. 21849 USA or items 23e Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give Marine Year or Dates: Corp Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced white "natural", Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Air Control Plumber 12 markad othar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Dueberry Mable Sonnaburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i Gladys Deuberry/wife 32776 Old Ocean City Rd., Parsonsburg, MD 21849 othar t 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Maryland Veterans 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō 8/23/05 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CESP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WEON ARY LTER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death. Funeral Director: A Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours To the Funeral Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47664 August 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md C. V. Surgical Associate PA 201 Pine Brug Bd Sal Md 21861

State Registrar

AUG 2 3 2005

DHMH 17 Rev 1/2001

General & Sparle

554 -14

Maryland 21215-0036 Baltimore,

> Box 68760 P.O. Records, Division of Vital

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2134 Louise Dolby 19, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Wicam co REGIONAL Medica PONIN SULP 3AL13B41 If Under 1 Year | If Under 24 H/s 8. Date of Birth 0-24-249. Birthplace (State or Foreign (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 302-14-2257 **Director** $\frac{78}{}$ 80 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked othar than "natural", or Items 23a or 28e-f show eny injury or othar traumatic evant, I'm Medical Examinst must be notified at 1X Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 905 Winding Way 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No Be Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willard Hamilton Ethel Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George B. Dolby/husband 905 Winding Way, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/24/05 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility
Holloway Funeral Home Professional Association Funeral Service Licensee Holloway Funderal Home Profes
501 Snow Hill Rd., Salisbury
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as consequence of). < 1 wk /Medical Examiner obstr. made Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit un Due to (or as a consequence of): the ! as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Hipatient 2 ER/Outpatient Certification: To 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HOO 61327 mer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula Regional Medical Center SALISBURY, Md. GIBMER. Mi). 31. Date filed (Month, Day, State AUG 2 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar Amended items 7 & 8 per fh/Certificate of Deathwichd/8-29-65/dis

State of Maryland / Department of Health and Mental Hygien 2005

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	P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a d. 23c. If yes, outcome of the pregnant at the pregnant	a consequence a consequence a consequence a consequence a consequence a consequence a consequence b consequence a consequence a consequence b consequence a consequence a consequence b consequence a consequence a consequence b consequence a consequence a consequence b consequence a consequence a consequence b consequence a consequence a consequence b consequence a	Dutpatien Time of Injury farm, stre	DEctopic pregnancy Other (specify) Inderlying cause give a SIDOA Other 28c. Injury Work 1 The set, factory, office a occurred at the time restigation, in my operation of the set of t	26. Place of or: 4 \(\text{Nurs} \) 7 es 2 \(\text{Not} \) Ne, date and obtainion, death as number	of Death (the sing Home 28) of 28 of	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 21 Check only one) 5	23d. Date signe	tribute to the 3 Proba Were autopprior to comdeath? 1 Yes 2 her (Specify) red ber or Rural anner as sta and due to the discount of the discoun	Poay Year a cause of death? bly 4 □Unknown sy findings available pletion of cause of P□ No Route Number, ted. the cause(s)

Amend Item Per doc 8847 Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2005 28957 Certificate of Death 1. Decedent's Name (First, Middle, Last) Donaldson Dora A. 2 Date of Death Mopth **Physician** dsan 2:30 26 /Medical Α. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick County Catherine's Nursing Center Emmitsburg If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□ M 25 F Yrs. Director 163-24-9152 Usual Residence of Decedent England 08-12-24 the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic evant, the Medical Examinar must be notified at Yes 2 No Director PAAdams County Fairfield Boro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 17320 208 East Main Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Specify: White ð 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Vice-President Shoe Manufacture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick T. Woods Ada C. L. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health au Important: If itam 27 Is any injury or other trau Jeanne C. Spielman/daughter 4330 N. Susquehanna Trail York, Pa. 17402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8-29-05 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium Smithsburg, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. L. Davis Funeral Home s thit caused the death. Do not enter the mide of dying, such as codiac or respiratory selections. ie, or complications List only one car's Smithsburg, MD 21783 23a, Part . Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 certificate be Physiclan/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 **A** No Yes 25. Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicay Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2610) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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SEP 0 2 2005

31. Date filed (Month, Day, Year)

310

MV

pegistrar's Signature

VIOIV

Seton

Emmitsburg

Md

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ian	1 - For State Registrar 1. Decedent's Name (First, Middle, La	oct)	Ce	rtificate of	Death	2. Date of Dea	Reg. No. 20 ()5	2.895 32.18.95		
	Terrill Antho					Month	-	Vaar	2:07 a.		
cal ner	4a. Facility Name (If not institution, given	4b. City. Town, o	or Location of Death		4c. County o		2:07 a.				
iei	Prince George's H		r	Cheverl			_	eorge's			
	5. Social Security Number 6.	Sex 7. Age (In yi	rs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	lace (State or Foreig			
-	578-15-4191 1M 2 F 24 Yrs. Months Days Hours Min. 0 2-19-1981								Wash.,D.C.		
F	10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limit		
호		V	Vashin	gton, D	.С.				, 1 □ Yes 2 🙀 N		
Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Coun	try?		
a l	225 15th Street S.E.			2000	3		USA				
Inel	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race Black	- Americ White,			
	1 Never Married 2 Married	1 ☐ Yes 2 🐼 No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	, , , , ,	Specify:	В1а			
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:									
lete	15. Decedent's Education (Specify only highest grade completed)			dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Kind of Bus	usiness/Industry			
Completed	Elementary/Secondary (0-12) College (1-4or 5+)			erk	0)		Me1woo	Me1wood			
	17. Father's Name (First, Middle, Last		12	18. Mother's Nam	ne (First, Middle,	Maiden Sumame					
ā	Unknown				n Wren	•					
<u>٩</u>	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	na Address (Street	and Number or Ru			tate Zin	Codel		
	Carolen Davis/				.,S.E.,				0000)		
	20a. Method of Disposition			osition (Name of matory or other pla	2000	Date	20c. Location - C		wn, State		
	1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				8/2	0 /05					
-	21. Signature of Funeral Service Lice										
	Pink INC	was moll	28.	Bak. HH	ss of Facility NRY FUN Street N	ERAL H	PME TIC	200	102		
	23a. Part1. Ent r the disease, or com							200	Approximate		
	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Interval Between Onset and Death		
	disease or condition resulting in death)	a Multiple	gunsho	t wounds							
	- (Due to (or as a cons	equence of):								
5	Sequentially list conditions, b										
	cause. Enter Underlying Cause (Disease or injury										
хаг	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):								
calE	· ·	8 .									
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	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy				23d Date	of delive	D/		
clar	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o	etal death 3[☐Ectopic pregnancy ☐ Other (specify)		23d. Date of o		Day Year			
ıysi	1 Yes 2 No 9 Unknown	9☐ Unknown									
by Pi	Part II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to th	e cause of death?		
-						1 🗆 Y	1 Yes 2 No 3 Probably 4				
9						24a. Was a	24b We	are autor	osy findings availabl		
leted b						autop	sy pri med? de	or to con ath?	npletion of cause of		
mpleted b						1 . —	2 □ No 1 1 2	Yes	2□ No		
Completed	GE Was area stored to resident	r				1 PYes					
Be Completed	25. Was case referred to medical examiner?	Hospital:		O#	26. Place of Dea	th (Check only or					
To Be Completed	examiner? 1X Yes 2 □ No	1 ☐ Inpatient 2	ER/Outpatie		er: 4 🗆 Nursing H	th <i>(Check only or</i> ome 5 ☐ Resid	ence 6 Other)		
To Be Completed	examiner? 1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	er: 4 Nursing Hoyat k?	th <i>(Check only or</i> ome 5 ☐ Resid)		
To Be Completed	examiner? 12 Yes 2 No 27 Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c Injur Wor	er: 4 🗆 Nursing H	th (Check only or ome 5 Resid 28d. Describe h	ence 6 Other ow injury occurred A Sha	1			
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Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Samia Η. Elmasry August 14, 2005 9:50pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 XF 579-08-1251 Director Yrs 59 OCT. 12. 1945 Egypt Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be invitiged at 1 Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2115 View Terrace Walsh 20902 death 1 Egypt 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other treumatic event, the Medical Examinat once. Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Vice President 13 GTE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) M. Mostafa Elmasry Nabawiea Soliman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mehmoud I. Kamal, M.D. / Husband 2115 Walsh View Terrace, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State AUG 15,2005 Laurel, Maryland ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD M00956 20910 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Immediate Cause (Hisease or condition resulting in death) Pnysician Malignant Melanoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listase or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 X No Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has rmed : 2€ No 1 Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 2 X ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 08.14.2005 D 24348 MN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 Steven Grufferman, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 19 2005 Registrar

Amended Item 25 per M.E. 08/19/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 28960 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 16 658 Jonald 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Mary land Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last binhday) Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | 8 / 1 9 / 1 9 29 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months Yrs. Director 218-24-9898 MARYLAND Usual Residence of Decedent the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f ahov Examinar must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director CUMBERLAND SHIPPENSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 RIDGE RD. 17257 USA 12. Was Decedent Ever in U.S. Amed Forces?
1 2 Yes 2 No If Yes, Give KOREAN Year or Dates: CONFLICT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itan any nijury or other traumatic event, Ita Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MASON CONSTRUCTION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FERDINAND LEWIS FRICK CLEEDIE VIOLA WILLIAMS ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - SON 510 RIDGE RD., SHIPPENSBURG.PA. 17257 BRUCE I. FRICK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DEER PARK CEMETERY 8/20/05 SMALLWOOD, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Viferal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ischemic Zdays disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Perforated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vicer 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 s autopsy rmed? 24 No Yes To the Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death.

Director: Af
d in by the fur 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours aft To the Funaral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number RES 000 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WJL AU4176435216535 August 16 STIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 22 South Greege Street

Registrar

201

AUG 1 9 2005

31. Date filed (Month, Day, Year)

Baltimore

State of Maryland / Department of Health and Mental Hygiene 28961 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician Fuller** Josephine Luverta August 14, 2005 7:50 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges The Millennium of Forestville **Forestville** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Hours Months Days Min. 1 ☐ M 2 🕱 F 83 October 8,1921 Washington,D.C Director 577-28-7207 Usual Residence of Decedent Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hyglene.
Intel if item 27 is marked other than "natural; or items 23a or 28a-1 show any or other than "natural" or other traumatic event, the Madical Exammet matter colline 1 at my or other traumatic event, the Madical Exammet matter colline 1 at 1
Yes 2□No Completed by Funeral Director Maryland Prince Georges Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7420 Marlboro Pike 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Elementary School Teacher D.C.Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Brooks Fuller, Sr. Catherine Alberta Hall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) Frances Maria Powell (Niece) 2401 Roslyn Avenue; District Heights, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 22, 2005 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. National Harmony Memorial Park Landover, Maryland 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc. 21 Signature of Funeral xanay 600 Kennedy Street, N.W.; Washington, D.C.. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The taw requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. E been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Diabetes Mellitus 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an page 2 s autopsy performed' Dementia 2**X** No 1 Yes 2 1 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 🗌 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a
To the Funeral C To the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) SOLCONKIND D0055314 August 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20745 Sylvester O. Okonkwo, M.D.; 6192 Oxon Hill Road; Suite 507; Oxon Hill, Maryland 31. Date filed (Month, Day, Year) AUG 2 2 2005 32. Registrar's Signature State Registra

			1 - For Stete Registrar	State of Maryla	nd / Department of I Certificate of		ntal Hygiene Reg. No	2005 28962
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last Nev Dev + Aa. Fecility Name (If not institution, give to the second of the second	e street and number) Core Cer	last birthday) If Under 1 Year	or Location of Deeth	nd	County of Death .
	Funeral Director			₩ ^{M 2□F} 76	Yrs. Months Days	Hours Min. Ma	Date of Birth (Month, Pay, Year) ay 15,19	10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23a or 28e-f show entry injury or other treumatic event, I're Medical Exactical must be coefficial and once.	Funeral Director	MD Cecil 10e. Street and Number 249 Douglas St		10f. Zip Code 2192	1	_	t Yes 2 No ven of What Country?
9036	nours after des urel', or items I Examiner m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of If Yes, specify Cub 1 □ Yes 2 □ No	Hispanic Origin? (Specify an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
121215-0036	led within 72 h lygiene. her then "netu it, the Medica	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Foreman	during most of working	Sta	nd of Business/Industry te Highway inistration
Maryland	2 should be fi and Mental H is marked otl eumatic ever	To Be	17. Father's Name (First, Middle, Last) Willie Fender 19a. Informant's Name/Relationship (1)	Гурө, Print)	19b. Mailing Address (Street		th Z. Ta	ylor
Imore,	Pages 1 and nent of Health ent: If Item 27 ary or other tr		Mary Walter/da 20a. Method of Disposition 1 → Buriai 2 □ Cremation 3 □ 1 → 1 □ Donation 5 □ Other (Specify	Removal from State	249 Dougla Place of Disposition (Name of commetery, crematory or other place 1 Air Memor	ial Augus	20c. Lo t 24,	21921 cation - City or Town, State Sel Air, MD
■ Balti	permit. Departr Importe eny inji		21. Signature of Fune 11. Service Licen 23a. Part1. Enter the disease, or comp	plications that caused the dea		ess of Facility G. Gee Fu	neral Ho	MD 21 221 ate
1	Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	quence of):			Interval Between Onset and Death
8760,	Attanding Physicien: The law requires that the death certificate be executed refeath certificate has been signed by the attending physician and sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	licai Examiner	Sequentially list conditions, if any learn to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to lor as a conse. c. Unuly Due to (or as a conse. d. Conyntric	quence all . fruit injects quence of): heast failu	U.		
P.O. Box 6	that the death certifics ed by the attending ph detached for use as II	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	el death 3 Ectopic pregnanc	у		23d. Date of delivery Month Day Year
ords, P.	w requires that the base of the consideration of the constant	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying cause gi	ven in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown
Vital Records,	iicien: The faw i certificate has bi rector, page 2 st	e Completed	Hyperdean Contom of 25. Was case referred to medica	altz		26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vi	r Attanding Physician: er death. rector; After this certific by the funeral director,	Certification; To B	examiner? 1 Yes 2 Ho 27. Manner of Death 1 Yhatural 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wo	ner: 4 Versing Home ry at 28d. rk? Yes 2 □ No	5 ☐ Residence 6. Describe how injury	occurred
Divi	afte Dir		4 Homicide determined 29a. Certifier 1 Certifying Ph	building, etc. (Specials)	owledge, death occurred at the ti	me, date and place, and	City or Town, State) due to the cause(s)	and manner as stated.
ļ	\cap	Medical	(Check only 2 Medical Exemple) 29b. Signature and title of certifier Am Ceel if a	and manner stated.	ation and/or investigation, in my of 29c. Licens	se number	29d. Date	a signed (Month, Day, Year)
		te -	30. Name and address of person who of the state of the st	tsu , MD	m 23a) (Type, Print) 223 Wet	nou A	aporto	12105 - MJ 2194

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 1 ten per Th 8047
State of Maryland / Department of Health and Mental Hygiene 10 5

005 28963 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death HAMMOND KENNETH FIELDS. JR. **Physician** 29 August 2005 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12812 Harney Road Taneytown Frederick County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday). 8. Date of Birth (Month, Day, Dec. 19 9. Birthplace (State or Foreign **Funeral** Year) 1933 Maryland Months Days Hours Min. 1**Д**М 2□ F -67213-32-6461 Dec. Director Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Frederick County Director Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 12812 Harney Road 21787 or Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 MYes 2 □ No 195 If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. If item 27 is marked othar than "natural; or Ital any injury or othar traumatic event, the Medical Examinar 1955-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced 1963 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) optician optical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be Kenneth Hammond Fields Hazel Elizabeth Colein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Curtis Fields / wife 12812 Harney Road Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) arg Crematorium 2005 SIIILLISDULG 22. Name and Address of Facility Skiles Funeral Home Smithsburg Crematorium 21. Signature of Funeral Service Licensee 136 East Baltimore Street Taneytown, Md. 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760. Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ eq cate has been sig , page 2 should b 1 Pres 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 21 1 Yes 2 No Division of Vital the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after 1 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year, 2 617 nd address of person who completed cause of death (Item 23a) (Type, Print) OREN 20 egistrar's Signature 31. Date filed (Month, Day, Year) State 550 1 Registrar

			State of Maryland / Department of Health and Messer State of Maryland / Department of Health and Messer State of Per FH, G847,09/23/05dhb	ental Hyg	giene 20 (5 2896				
Physician Millard B. Fleischer Millard B. Fleischer August 15, 2005										
	Examin	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	10:35 A M				
			4701 Willard Avenue #331 Chevy Chase		Montgome	ry				
	Funeral Director 5. Social Security Number 6. Sex 12 F 86 Yrs. 5. Social Security Number 216-01-5891 6. Sex 15 F 86 Yrs. 7. Age (In yrs. last birthday) 15 F 86 Yrs. 8. Date of Birth (Month, Day, Year) 4. April 12, 1919 1.									
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
	Mary -f sho	ţ	Maryland Montgomery Chevy Chase			1 Yes 2 No				
	r 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	Country?				
	th wit		5701 Willard Avenue #331 20815		U.S.A.					
36	d within 72 hours after death with the Maryland Jene. Ir then "neturel", or Items 23a or 28a-f show The Madical Examerations Contined at	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto Fit Yes, Sive Year or Dates: WW-II	cify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. Vhite				
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Jar	2 sh and Is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural							
e, l	1 and Health Bm 27 ther t	- 3	Sophia Fleischer / Spouse 4701 Willard Ave. #331 20a. Method of Disposition 20b. Place of Disposition (Name of	Chevy C	Chase, MD.					
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ij	it. Partmer	i	'4 □ Donation 5 □ Other (Specify) Mt. Comfort Crematory 200 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Togs.			, Virginia				
Ba	Depariment Department of the poores.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jose 5130 Wisconsin Ave.	epn Gaw N.W. W	ier's Sons	D.C. 20016				
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Division of	after death after death Director:	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or i m, State)	Rural Route Number,				
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	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only one) 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, o	date and place, and di	as stated. Leto the cause(s)				
	omple	Me	29b. Signature and fulle of pertifier 29c. License number	2	29d. Date signed (Mo	nth, Day, Year)				
			D42051		August 16,	2005				
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0					
			D. Scott Cohen, M.D. 5530 Wisconsin Ave. Suite 930 Ch	nevy Cha	ase, Maryl	and 20815				
:-	Sta		AUG 1 9 2005 33 Registrar's Signature							
	Registi	ar	AUG 19 2005 Brown St. Sparke							

State of Maryland / Department of Health and Mental Hygien 205 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Aonth. Day Year & ward homas Moust 2005 /Medical 16 Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death Ohn None 24 Hrs. Under 1 5. Social Security Number Funeral 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Nov 19. 1 Days Hours Months Min. 1 XM 2 □ F 048 32 7553 **Director** 64 Yrs 1940 Vermont Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itams 23s or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Examiner paratible notified at Director 1 Yes 2 No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8048 Nightwind Court 21075 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 M Married 1 XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced unknown White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Project Manager Engineering 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Wesley Samuel Farr Frances Josephine McGolflin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen R. Farr/Wife 8048 Nightwind Court Elkridge, MD 21075 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State injury or permit. Page Department of Important: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-19-2005 Catonsville, MD 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) ecurren 7 WR.CIT /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760 attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No Yes Yes 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2XNo Other: 2 1 Tyes patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After. 28d. Describe how injury occurred Injury Natural 5 Pending death. Diractor: A 2 Accident investigation 1 Tyes 2 TNo 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) m.D. 125-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hopkins Hospital son North Wolfe Street, Baltimore Mustagha Saherd 31. Date filed (Month, Day, ALIC 22 State

Registrar

Examir

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	•	1 - State Registrar	Cer	tificate of Dea	ath	Re	g. No.	10	2090	סכ
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edic		EVA MAE GRIMES					7, 200	5	8:00 A	М
min	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca			4c. County			
		3700 LIVINGSTON ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	hirthdayl	INDIAN I	ndor 24 Hrs	8. Date of Birth	1	RLES	Jane (Ctata as 5	
ral tor		5.599-42-7504 1 M 2X F 73 Usual Residence of Decedent	Yrs.		urs Min.	JAN 25,	1932		lace (State or Fe atry) ANIA	oreign
í	Ì	10a. State 10b. County 10c. City, Tow	wn or Loc	cation				1	0d. Inside City L	imits
	Director	MARYLAND CHARLES	I	NDIAN HEAD					1 🗆 Yes 2X	(X No
	al Dir	3700 LIVINGSTON ROAD		10f. Zip Code 2064	10	10	g. Citizen of V UNIT	What Coun	•	
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	atlon:		. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		28d. Describe ho	w injury occurr	ed		
	ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Str City or Town		er or Rura	l Route Number,	,
	Medical Certification;	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	ge, death and/or inv	occurred at the time, da estigation, in my opinion	ite and place, a	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as stand due to	ated. the cause(s)	
	Me	29b. Signature and title of centier		29c. License num	443	/	d. Date signed			
		30. Name and address of person who completed cause of death (Item 23a)		Print)			UGUST :	10, 2	.000	
		ASHVIN J. PATEL, MD, 102 PAUL MEL	LON.	CT. #102, W	IALDORF	, MD 206	02			
Sta istr		31. Date filed (Month, Day, Year) AUG 2 2 2005 32. Refistrar's Signature	· A	berke						

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28967 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 14, 2005 7:50 a M Martha C. Gourdouros /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11313 Rouen Drive Montgomery Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months Min. 1 □ M 2 🔀 F 85 Director 041.14.5122 May 5, Connecticut Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury og other treumatic event, the Madical Extendibut out by notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11313 Rouen Drive 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Basil Chekas Stravru1a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11313 Rouen Drive 20854 Peter T. Gourdouros/ Husband Potomac, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Aug. 18, 2005 Silver Spring, MD A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee neh k 5130 Wisconsin Avenue NW WDC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 SOUTIAT 10 3111 SHI /Medical Due to (or as a consequence of): Examiner 4017450188A HI CHOOPOST MS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit 七年のかっ 301250000 that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month in the past 12 months? Year Dav 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 2 No 3 Probably 4 □Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☑No To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 2 2 ER/Outpatient 3□ DOA ithin 24 hours after death.

o the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Anatural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 29c. License number H8051280 8 - 10 - Japa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar-Dehkordi, M.D. 13219 Executive Park Terr; Germantown, MD 20874 32. Pagistrar's Signature 31. Date filed (Month State CHEVE. Registrar

			1 - For State Registrar	State of Ma	aryland /	Depa Cer	artment of F rtificate of	łealth a <i>Death</i>	nd M	lental I	Hygie Reg	ene 20	05	2896	
100	Physic /Medi		1. Decedent's Name (First, Middle, Last) Kathryn Garrett						2. Date of De Month August			Day 18 20	3. Time of Death 7:00 a M		
	Examir Funeral Director		4a. Facility Name (If not institution, Anne Arundel N 5. Social Security Number 6 577-01-6545	Medical Cent	cer e (In yrs. last bi 92	rthday) Yrs.	Annapo If Under 1 Year Months Days	lis		8. Date o (Month Apr.	Day, Y	Anne Par)	Aru 9. Birthpl Count		
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036	with the M te or 28a-f	Director	MD Anne A 10e. Street and Number 1059 Springhill		Gam	bri	10f. Zip Code				10g	. Citizen of W	hat Count	1 ☐ Yes 2 X No	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Iteme 23a or 28a-f show aumetic event, it a Medical Exertinal marked of the rediffied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	Ever in U.S.		Vas Decedent of H f Yes, specify Cuba		in? (Spe Puerto l	cify Yes o Rican, etc.	r No-	14. Race Black Specify:		tc.	
Maryland 21215-0036	d within 72 hor giene. ir then "naturi the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) Switchboard Operator				ng		Sb. Kind of Business/Industry			
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	ges 1 and 2 should it of Health and Mer if Item 27 is marks or other traumetic		19a. Informant's Name/Relationship Michele Garrett 20a. Method of Disposition		1	059	g Address (Street a	11 Way	7. Ģ	ambri	11s,	MD 21	054		
Baltimore,	permit. Pages : Department of H Importent: If Ite eny Injury or ot		1 ☐ Burial XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)		Cre	sition (Name of natory or other place ematory	8	3-19	^{ate} -2005	Ва	Location - C	,	,	
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IVISION OF VI	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ertification; To Be	5 B	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 2 Accident investigate		/28b.]	tpatient Time of njury	28c. Injury Work	4 Nurs	ing Hom	ne 5□R	esidence	6 Other		
Ž	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	O	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc.	(Specify)					City or	Town, Si	ate)		Route Number,	
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	7 × 3		And rulling 30. Name and address of person wh	d Skynn h	ath (Item 23a) (Тура, Р	Print)	57070			0	Date signed (- 05	_	
- N. S.	Sta	е	Ja (g win Ro 31. Date filed (Month, Day, Year) AUG 19	4au MD 20	001 Mb	deen	(Parter	ray	Ann	apoli	s M	0 214	101		
	Registr	ar .	MOD 1.3	ZUUD DE	w St	A	molks.								

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 1 - For State Registrar 28969 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Frances Galvin 16 2005 8:55 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunrise Assisted Living Annapolis Anne Arundel 8. Date of Birth (Month, Oay, Year) If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□ F 579-22-7721 Director 26,1925 North Carolina Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show other traumatic event, the Mudical Examinational be notified at 1X Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 619 Admiral Drive, Unit 404 21401 itams 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "neturel", or Itar 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White À Specify Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Herbert E. Gaskins, Sr. Leonia C. Wiggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 and 2 s of Health an item 27 is John A. Galvin (Husband) 619 Admiral Drive, Unit 404, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot XXBurial 2 Cremation 3 Removal from State Maryland Vet. Cem. 8-22-2005 * 4 □ Donation 5 □ Other (Specify) Crownsville, MD 22. Name and Address of Facility
HardestyFuneral Home, P.A. 21. Sign tu e of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 23a. art1 Enter he d sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he, it falure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi disease of condition resulting in death (Fi al Physician ardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuas or ir jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Dunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 TYAS 2 No 1□ Yes 2□100 To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 🗌 Residence 6 Other (Specify) 2 this funeral Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? ulceo After Certification: Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chopra M.D. 600 Ridge State AUG 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28970 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Ruth E. Hopkins 2005 8.50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Western Maryland Hospital Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Aug. 9, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land 6. Sex **Funeral** 1 □ M 200 F 212-12-2937 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits other traumatic evant, the Medical Examiner must be notified at Washington Maryland Hagerstown X□Yes 2□No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 Pennsylvania Avenue 21742 U.S.A. Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② Wo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ō Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White 3 XWidowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed wrum. In and Mentat Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last)
C. Roland Mackley 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Esterly Department of Health and 2 shu Department of Health and Important: If itam 27 la ma any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Connie Testerman, cousin 13284 Penn Shop Court, Mt. Airy, MD 21771 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory Sept. 1, 2005 Smithsburg, MD ^¹ 4 □ Donation 5 □ Other (Specify) ²² Name and Address of Facility
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee M00255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) fewere due to Advanced Mulliple Sclerosis **Physician** /Medical Due to (or as a consequence of): Examiner to Abvanced Muliple Schroses DYSPIFABLA du Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Generalized anding physicien and use as the burial-transit Due to (or as a onsequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 1 Tes 2 0 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To tha Funeral Dira 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 046561 2005 Widu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue (DA) 5/mms Hagerstown, MD 21742 31. Date filed (Month, Day, Year) SEP 0 6 2005 32. Registrar's Signature State Registrar

Ruth E. Hopkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 28971 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 21, 2005 10:00 PM ESTHER R. HITCHNER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico Salisbury Rehab & Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

10f. Zîp Code

1 ☐ Yes 2 🗓 No

RN

22. Name and Address of Facility

16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PITTSGROVE CEMETERY

21804

during most of working

18. Mother's Name (First, Middle, Maiden Surname)

705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

SARAH R. BALLINGER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

08-24-2005

921 WINDING WAY, SALISBURY, MARYLAND 21804

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

filed within 72 hours after death with the Maryland orient: if item 27 is marked other than "neturel", or items 23e or 28e-f show injury or other treumatic event, the Medical Examinar must be notified at d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r

Physician

/Medical

Examiner

Director

Funeral

Director

if item 27

Priysician /Medical

that the death certificate be executed burial-tran attending physician for use as the buria ed by the detached i or Attending Physicien: after death.

within 24 hours a

Division of Vital Records. P.O. Box 68760

Examiner Physician/Medical Be ပို Certification:

Be IF FEMALE: 1 Maturai 2 Accident 3 Suicide

by Funeral 1 XNever Married 2 Married 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 9 Unknown

163-24-3151

10a. State

MD

10e. Street and Number

Usual Residence of Decedent

10b. County

WICOMICO

1109 SOUTH SHOEMAKER DRIVE

HERBERT R. HITCHNER 19a. Informant's Name/Relationship (Type, Print) STEPHEN HITCHNER - BROTHER 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 5 Pending investigation

4 Homicide

29b. Signature and title of certifier

29a. Certifier

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 Could not be

determined

1 □ M 2√□ F

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+) 14+

C(c

Due to (or as a consequence of).

Due to (ny as a consequence of)

Due to (or as a consequence of):

93

10c. City, Town or Location

SALISBURY

4☐Pregnant at time of death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of Injury (Month, Day Year)

ja

5 ☐ Other (specify)

3 □Ectopic pregnancy

23d. Date of delivery Month

DARETOWN, N.J.

10g. Citizen of What Country?

USA

Race - American Indian, Black, White, etc.

Specify: WHITE

16b. Kind of Business/Industry

MEDICAL / HEALTH

20c. Location - City or Town, State

BOUNDS FUNERAL HOME, INC.

PITTSGROVE, NEW JERSEY

Approximate Interval Between Onset and Death

1101

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 2 No 26. Place of Death (Check only one)

Other: 4 vursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ray 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 Civic Ave. Salisbury, MD

William H. Robins, M.D.

AUG 2 3 2005

gistrar's Signature Seren

State

Registrar

State of Maryland / Department of Health and Mental Hygiena 28972 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year **Physician** g William Howard August 21, 2005 8:00 /Medical 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) 4c. County of Death Examiner 229 Canal Park Dr., Apt. 307 Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□ F Months Days Hours Min. 99 Yrs. Director 213-22-8144 2/13/1906 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show or Itams 23a or 28a-f shover intermet the notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 Canal Park Dr., Apt. 307 USA 14. Race - American Indian, 21804 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other treumatic event, the Mudical Examiner of 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: white 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 Doctor Opthalmology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John W. Howard Leona Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred H. Howard/wife 229 Canal Park Dr., Apt. 307, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stephens Park Cemetery 8/25/05 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical d as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ in she anu 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pace 2 autopsy performe 1 ☐ Yes 2 X No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 147094 8/23/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57/15hum MD 21804 1415 SoulF stur DI VISION Naleson Vel 31. Date filed (Month, istrar's Signature State 3 2005 Registrar

			For State Registrar	State	of Maryla	ind / Depa <i>Cei</i>	artment of F	lealth and Death	Mental Hy	giene2	005	28973
Ì	Physici /Medi		Decedent's Name (First, Middle Evelyn		k i ns				2. Date of De Month 08	Day	Year 05	3. Time of Death 4:05P M
	Examir		4a. Facility Name (If not institution) 4318 Taverngree	•	umber)		4b. City, Town, o	r Location of Dea	th		nty of Death	orges
	Funeral Director		5. Social Security Number 578–12–7323	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yr. 94	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th.	9. Birthp	place (State or Foreign ntry) ington, D.C
	inyland show		Usual Residence of Decedent 10a. State 10b. County		10c. 0	City, Town or Lo	cation				1	10d. Inside City Limits
	the Ma	Director	D • C • 10e. Street and Number			Washing	10f. Zip Code			10g. Citizen	of What Cour	Y Yes 2 No ntry?
	th with		2017 Lawrence	Street	N.E.		2001	8			USA	
36	be filed within 72 hours after death with the Maryland tlat Hyglene. Id Hyglene. Id other then "natural", or Itams 23s or 28e-f show avent, it's Madical Examinat must be invitted at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ፟ Divorced	Armed F	2 🔯 No ≩ive	1	Vas Decedent of H fYes, specify Cuba □ Yes 2X No	lispanic Origin? (§ an, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	E	Race - Americ Black, White, cify: Bla	etc.
21215-0036	hin 72 hou a. an "natura Modical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed		(Give	lent's Usual Occup kind of work done o DO NOT use retired	durina most of wa	orking	16b. Kind of	Business/In	dustry
121	fled wit fygien har the	Con	17. Father's Name (First, Middle, I	2 y	rs.	Nu	ırse	10. Mathada Na	me (First, Middle	1	Govern	nment
land	m - 0 &	To Be	Edward Lane	.431/					Covingt		airie)	
Maryland	2 should be filed withir and Mental Hygiene. Ia marked othar then aumatic avent, ITV M	_	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City or Tov	vn, State, Zip	Code)
	1 and Health Brn 27 ther tr		Theresa Clark-	Tames/Gra	ınddaugl	nter 43	318 Taver	ngreen I	ane, Boy	vie, MI	n - City or To	20 State
altimore,	Pages ent of nt: If it ry or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	cemetery, cren	emorial P		L6 - 05	LAndov		
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Ia marked any injury or other traumatic av <u>once.</u>		21. Signature of Funeral Service L	icensee			. Name and Addres	ric	arshall's Washing			
			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that	caused the de						7.0. 2	Approximate Interval Between
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ticemia							Onset and Death
	Examiner				o (or as a conse ngrene (
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		o (or as a conse							
,09,	icate be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last		ipheral (or as a conse		<u> Disea</u>	se				
68760	rtificate ng phys as the	Medical	IF FEMALE:	0.								
O. Box	at the death certific by the attending pi tached for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of preg birth 2 Te gnant at time of nown	tal death 3	Ectopic pregnancy Other (specify)	,			Date of delive Month	Day Year
J.	as tha	by	Part II. Other significant conditio	ns contributing to	death but not re	esulting in the un	nderlying cause give	en in Part I.				ne cause of death?
Records,	0 4 0	Completed							24a. Was autop perfo 1 Yes		prior to cor death?	psy findings available impletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ch	26. Place of De	ath (Check only o	one)		
ō	Phys this ral di	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date	Inpatient 2 [e of Injury nth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Worl		Home 5 Resident Resid			7
Division	To the Hospital or Attanding within 24 hours after death. To tha Funarel Director: Attencompletely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	ce of Injury - At ding, etc. (Spec		eet, factory, office		28f. Location (S City or Tox	Street and Nui wn, State)	mber or Rura	l Route Number,
	To the Hospital or Al within 24 hours after or To the Funarel Direc completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical B	xaminer: On the	ne best of my kr basis of examir nner stated.	nowledge, death nation and/orny	occurred at the timestigation, in my of	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	ne V	an	ad	29c. License			29d. Date sign		
2	6		30. Name and address of person v	who completed car	use of death (Ite	em 23a) (Type. I	7 110	17310		Augus	st 11,	2005
	(8)		Dr. Uma Prosa	d, M.D.	2100 P	ennsylv	ania Ave.	N.W. Wa	ashingto	n, D.C.	2003	7
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 9 2	005	Hegistrar's Sigi	fature for	E)					

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Approximate shock or near failure. Earning leaves or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or near failure. List only one cause on each line. Internet Betwee Oriest and Death (Medical Examiner) Approximate of the complete of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause (Final resulting in death) Approximate of the cause of the	<u>a</u>	Menta Menta arked atic a	To	Levi R. Hallen					Mar	y E.	Norber	.d		
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Part Part	Г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each li	d the death. Do no								
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Sequentially ist conditions, if any, leading to immediate yring and grant in the past 12 months? Due to (or as a consequence of): AORTIC Stenosis Due to (or as a consequence of): ACTIC Stenosis Due to (or as a consequence of preparatory ACT				resulting in death)	Due to (or as	a consequence o	•							
Aportic Stenosis Due to (or as a consequence of): FEMALE:		LAdillinei	<u></u>	Sequentially list conditions,	b			re						
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26. Place of Death (Check only one) 27. Manner of Death 1	r		Com								perfor	med?	death?	
A Could not be determined 1	<u> </u>	clan: ertifica ector,	a							of Death (C				
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29a. Certifier (Check only 29miner) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855	S	s afte	Cert	4 Homicide	building, et	tc. (Specity)					City or low	n, State)		
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			For State Registrar	State	of Marylar	nd / Depa	artme <i>rtifica</i>	ent of H ate of L	ealth and Death	d Men	tal Hyg	iene 0	05	28975
H	图 建山 一点		1. Decedent's Name (First, Middle,	•							Date of Deat	h Dav	Year	3. Time of Death
В	Physici /Medic		Anne Herring	ton Has	kett						yonth Lege		2000	11:50 PM
	Examin		4a. Facility Name (If not institution, g				4b. Ci	ty, Town, or	Location of De	eath		4c. County	of Death	
3.4			Shady Grove A				16 1 100	Roc	kville	Uro lo -				mery
8	Funeral		5. Social Security Number 016–16–7924	.Sex 1 ☐ M 2 💢 F	7. Age (In yrs.		Month			Ain.	Date of Birth Month, Day,	Year)	Cou	place (State or Foreign Intry)
	Director		Usual Residence of Decedent		87					Ma	rch l	4, 1918	MC MC)
	yland now		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mar	tor	MD Montg	omery		W	ashi	ngton	Grove					1 XYes 2 □ No
	or 284	lrec	10e. Street and Number					Zip Code	020,0		11	0g. Citizen of \	What Cou	intry?
	23a (2	205 Grove Road					2088	0			Unit	ed S	tates
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "saleal Exertinal rusal be notilled at	Funeral Director	11. Marital Status	Armed F	orces?		Was De	cedent of Hi pecify Cuba	spanic Origin? n, Mexican, Pi	(Specify uerto Rica	Yes or No- n, etc.)		e - Ameri k, White	ican Indian, , etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 XNo		1 🗌 Yes	2 X No	Specify:			Specify	<i>r</i> :	
21215-0036	hour tural	pe p	15. Decedent's	Year or	Jaies.	16a Dece	dent's II	sual Occupa	ation			16b. Kind of B	isinoss/li	White
5	in 72 "na" r	Completed	(Specify only highest	grade completed		(Give	kind of		turing most of	working		TOD. KING OF D	25111032411	loustry
212	y with jiene. r thai	E	Elementary/Secondary (0-12)	5+	(1-4or 5+) -		Но	memak	er			Own H	ome	
	be filed ntal Hygie od other	Be C	17. Father's Name (First, Middle, La	st)					18. Mother's	Name (Fir	st, Middle, M	Maiden Surnan		
/lar	Wents Wents wrked	ToE	Hunley Herrin	gton					Ly	ydia	Sumne	<u> </u>		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I them 23 or 28a-1 show item 27 Ie marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exertical must be notified at		19a. Informant's Name/Relationship	(Type, Print)								City or Town,		·
	and ealth m 27		Nancy Haskett	/ Daught	_							ove, MD		
altimore,	P = P P		20a. Method of Disposition 1 Darial 2 XCremation 3	☐Removal from	Ctata	Place of Dispo	matory o	r other plac	٠, –	2005 ^{ste}		20c. Location -	*	
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Bal	permit. Pages to Deportment of H Important: If its any Injury or ot once.		21. Signature of Funeral Service Lic	Stuve		D.	2. Name eer	and Addres	Drive,	Gait	Funer hersbu	ral Hom urg, MD	e, 1 208	0 East 77
1-2			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	caused the dea each line.	th. Do not ent	ter the m	ode of dyin	g, such as care	diac or res	spiratory arre	est,		Approximate Interval Between
И	Physician		Immediate Cause (Final disease or condition	a Se	ptic !	Shock								Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):	-	^						
В	- Adminior	e	Sequentially list our citions,	0	o (or as a conse	ureus		130 ct	שונה שם) have				i days
	ted Isit	nine	Sequentially liet on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0.	(or as a conse	quence of): The on	. 6		0.1	. 1501	_	4 2		51
	cate be executed physicien and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	or as a conse	quence of):	1005	'5 /	V-UCM	nay	20	nochue	-	3 augs
8760,	sicier buria	dicai E		l n	ement	ia							i i	4 years
687	ficate g phy: as the	Φ !		u										
Box	death certific e attending p od for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		7					23d. Da	te of deliv	rery
Ď	death e atte	icia	in the past 12 months? 1 □ Yes 2 🕱 No	4□Preg	birth 2 ☐ Feta Inant at time of			pregnancy (specify)				Mo	nth	Day Year
P.0.	that the de ed by the detached	hys	9 ☐ Unknown	9□ Unk	nown				-301.14					
S, F	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to	death but not re	sutting in the u	nderlyin	g cause give	en in Part I.		23e. Did tob	acco use cont		the cause of death?
ord	v requires been sign should be	ted								- [1 🗌 Ye	s 2 No	3 Pro	bably 4 Moknown
ecc	e law r has be	Completed								_	24a. Was ar autops		Nere auto	opsy findings available ompletion of cause of
<u>س</u>	Th ate pag	Con									perforn	ned?	death?	2 🗆 No
Vital Records,	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hannitale	80.				26. Place of	Death (Ch	eck only on	9)		
of o	d is	5	1 ☐ Yes 2 ☑ No			ER/Outpatier		DOA Othe	4 1 14012111			nce 6 Oth		fy)
n	Jing A	io	27. Manner of Death 1 SNatural 5 □ Pending		nth, Day Year)	28b. Time o Injury	М	28c. Injury Work	rat ⟨? Yes 2 □ No	280.	Describe no	w injury occur	ea	
<u>si</u>	Attending r death, ector: After by the fune	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 390 Plac	e of Injury - At h	nome farm str		1	163 2 100	28f I	ocation (St	reet and Numb	er or Rur	al Route Number.
Division of	after Dire	Certification:	4 Homicide determine		ding, etc. (Speci			ory, omeo			City or Town		0, 0, 1, 0	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Pertifying (Check only one) 2 Medical Exponel	Physician: To the	basis of examin	owledge, deat ation and/or in	h occum vestigati	ed at the tim on, in my op	ne, date and pl pinion, death o	ace, and o	due to the ca the time, da	use(s) and ma	inner as s and due t	stated. to the cause(s)
	To the within 2 To the Complet	one) and manner stated. 29b. Signature and title of certifier 29c. License number									25	9d. Date signe	i (Month,	Day, Year)
	F 3 F ŏ) IAA					000	630 €	٤		-		9,2005
,	10		30. Name and address of person wh	no completed car	use of death (Ite	m 23a) (Type		, J J J				rayer	^ /	1, 2003
			Dr. Mohit Rasto	gi, 9901	Medica	1 Cente	er D	rive,	Rockvi	.11e,	MD 20	850		
	Sta		31. Date filed (Month, Day, Year)	2005 32	egistrar's Sign	ature	ast's	9						
	Registr	ar	AUG 22	2005	PRINCES .	Kr M	ORDER OF STREET							

			1- State of Maryland / Department of Health a Certificate of Death	and Men	tal Hygi	^{ene} 2 0 0	5 28976
ı	Physici		1. Decedent's Name (First, Middle, Last) Paul Liang-Chi Horng		Date of Death Month Igust	Day Y	3. Time of Death 005 2:55 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Bethesda		gust	4c. County of	
	Funeral Director		5. Social Security Number 6. Sex Yang Months Days Hours 156-68-7269 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	Min. (Date of Birth Month, Day,	Year)	9. Birthplace (State or Foreign Country) Taiwan
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	120	2,	17.13	10d. Inside City Limits
	8a-1 ah	Funeral Director	MD Montgomery Silver Spring				1 □ Yes 2√√ No
	a or 2	Dire	10e. Street and Number 1611 Spottsworth Way 20905			g. Citizen of Wh I nited S	
	ns 23	eral	1611 Spottsworth Way 20905 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig	gin? (Specify			American Indian,
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury at other traumatic avant, the Medical Examination in Item Contests once.	þ	If Yes, Give 1 \(\text{Yes}\) Yes 2 \(\text{YNO}\) Specify: Year or Dates:	i, Puerto Rica	in, etc.)	ļ	White, etc. Asian
Maryland 21215-0036	in 72 hoi n "natura edical I	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working	1	6b. Kind of Busi	ness/Industry
212	d with giene.	om	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Environmental Scien	ntist	F	ederal	Government
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<u> ≤</u>	d Men narke natic	10	H1 H0 Horng	Wu Nu Rural Ro	uto Alumbar	City or Town St	tata Zin Coda)
ā Z	nd 2 st lth and 27 is r traun		19a. Informant's Name/Relationship (Type, Print) Peggy Horng, Spouse 19b. Mailing Address (Street and Number) 19th Mailing Address (Street and Number)				
Jre,	of Healitam		20a. Method of Disposition 20b. Place of Disposition (Name of	Date			ity or Town, State
<u>m</u>	Page until E		'4 Donation 5 Other (Specify) Gate of Heaven Cem.				ring, MD
Baltimore,	permit. Departimports any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11800 New Hampsh	hire A	ve Sil	ver Spr	· ·
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart fairlie. List only one cause on each line. Immediate Cause (Final disease or condition Cardiac Arrythmia	cardiac or res	spiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
E		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C				
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9	eath certificat attending phy for use as th	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy				
.O. Box	the attentiched for us	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1			23d. Date Month	· ·
s, P.	ires that the de signed by the a d be detached t	by Ph			23e. Did toba	acco use contrib	ute to the cause of death?
rds	w requires been sig should b	ed b	Liver Transplant for treatment of Hemochromatosis		1 🗌 Yes	s 2 ½ No 3	Probably 4 Unknown
Vital Record	Physician: The law requires that the rthis certificate has been signed by the rail director, page 2 should be detached.	Completed	Chronic Atrial Fibrillation		24a. Was an autopsy perform	ed? dea	ere autopsy findings available or to completion of cause of ath?
ital	cian: artifica actor, p	Bec	25. Was case referred to medical	of Death (Ch	neck only one)	AA
of	g Physician: ter this certific neral director,	은	MXYes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 🕱 DOA Other: 4 □ Nurs			nce 6 Other winjury occurred	
Division	Attending ir death. actor: After by the fune	icatic	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined elemined. 28e. Place of Injury - At home, farm, street, factory, office		Location /Str	eet and Number	or Rural Route Number,
<u>></u>	tal or A rs after al Dirac ed in by	Certification:	4 Homicide determined determined building, etc. (Specify)		City or Town,		or ridger riodio realiser,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.				
	To the Vithin 2 To the Complet	Ž	29b. Signature and title of certifier 29c. License number	210	29		Month, Day, Year) 18, 2005
•	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			5451	10, 2003
	1		Lynt Johnson, M.D. 3800 Reservoir Road, NW Washingt	ton, D	C_2000	7	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 2 2005 32. Pegistrar's Signature				

			1 - State of Maryland / De Registrar	partment of Health and Mertificate of Death	Mental Hygie Reg.	ne2005 28977
	Physici /Medio		Decedent's Name (First, Middle, Last) MARIE HUTTON		2. Date of Death Month	Day Year 16 2005 7:50 P M
	Examir		4a. Facility Name (If not institution, give street and number) VILLA ROSA NURSING HOME	4b. City, Town, or Location of Death		4c. County of Death PRINCE GEORGE'S
	Funeral Director		5. Social Security Number 181-26-1430 Usual Residence of Decedent	Months Days Hours Min	8. Date of Birth (Month, Day, Ye MARCH 25	ar) 9. Birthplace (State or Foreign Country) 1919 PITTSBURG
	72 hours after death with the Maryland neturel', or Items 23a or 28a-f ehow lical Examined must be notified at	Funeral Director	10a. State	MARLBORO 10f. Zip Code 20774 3. Was Decedent of Hispanic Origin? (Sp.	U.S	10d. Inside City Limits 1 Yes 2 No Citizen of What Country? S . A . 14. Race - American Indian,
Maryland 21215-0036	72 hours after "naturel", or Ite	þ	Amed Forces? 1 Never Married 2 Married 1 1 Yes, 2 Mo 3 Midowed 4 Divorced Year or Dates: 15. Decedent's Education (Given for the following formulated) 16a. Dec. (Given for the formulated)	If Yes, specify Cuban, Mexican, Pueric 1 ☐ Yes 2 🌣 No Specify: Sedent's Usual Occupation we kind of work done during most of work	Rican, etc.)	Black, White, etc. Specify: BLACK Kind of Business/Industry
d 2121	filed within 7; I Hygiene. other then "n ent, II e Modi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	RSE		RIVATE
ırylan	5 5 5 5	To Be	LEE THOMAS HARRIS	ESTELLE illing Address (Street and Number or Rur	WEST	
Baltimore, Ma	tand 2 Health a tem 27 is		MARLENE RUSTON/DAUGHTER 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Discemetery, completely, co	STATON DRIVE UPPER position (Name of emalory or other place)	MARIBO RO,	MARYLAND 20774 Location - City or Town, State
Baltir	permit. Pages Department of Importent: If i eny injury or once.	0 0	21. Signature of Funeral Service Licensee	ny Cemetery 8/24, 22. Name and Address of Facility J. 7474 LANDOVER ROAD	B. JENKI	TTSBURG, PA. NS FUNERAL HOME MARYLAND 20785
	Pnysician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do not estable, or heart failure. It is tonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury that initiated events resulting in death) Last b. Seizure Disorder Due to (or as a consequence of): Dementia Due to (or as a consequence of):			
.O. Box 6	death certifi e attending p d for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ∑Unknown
I Record		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2X No
ion of Vital	Attending Physicien: Thr death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 Xo 1 Anner of Death 1 XoNatural 5 Pending 2 Accident investigation 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpati 28b. Time (Month, Day Year)	ent 3 DOA Cther: 4X Nursing Holor 28c. Injury at	me 5 Residence 28d. Describe how in	6 □Other (Specify) iury occurred
Division	Hospitel or Attend 44 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, tte)
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dead on the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and titler of certifier Koukon Monay M	D 20108	29d. D	Pate signed (Month, Day, Year)
K	w 1		30. Name and address of person who completed cause of death (Item 23a) (Type RAKESH ARORA M.D. 14300 GALLANT	p. Print) FOX LN # 222 BOWIE	. MARYLANI	20715
	Sta Registra	_	31. Pate filed (Month, Day, Year) AUG 2 2 2005 Security 132. Registrar's Signature		,	20113

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al	4a Facility I

Physici /Medi **Examiner**

Funeral Director

Directo

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Completed

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GEORGE

TO PHYSICIAN: HOLLEY,

Maryland 21215-0036

Baltimore, NAME KNOWN

the Maryland 7 is marked other than "natural", or Items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at with within 72 hours after nd Mental Hygiene. marked other than th and Mental F

Physician

Pages 1 and 2 ment of Health a ant: If Item 27 I

other

injury or Department Important: If any injury or once.

Box 68760 P.0. Records. Division of Vital Physician: death.

/Medical **Examiner** Examine burial-transit attending physician Physician/Medical use as the ō the detached signed by þ Completed Be ျှ Certification: After or Attending after death within 24 hours a cal IVA

Certificate of Death trar Reg. No. it's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year George Holley, Jr. 3:55 P.™ JULY 24 2005 a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PERRY POINT CECIL VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1⊠M 2□F 71 Yrs. 215-28-0539 19,1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3600 West Franklin Street, Apt. 12P 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XYes 2 No 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1952-53 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Holley Maggie (maiden name unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliqibility Clerk Aimee Saylor V.A. Maryland Health Care System (136A), Perry Point, MD 21902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cemetery 4 □ Donation 5 □ Other (Specify) Owings Mills, Maryland 08/26/05 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licensee Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) UNKNOWN MULTIPLE SCLEROSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequênce of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Henknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmea? 2X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 🛮 Natural 5 Pending investigation 1 Tes 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number none VA01010581201 JULY 24, 2005 jany 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 05--5420 B.K.S JACK HESSMAN

Amend item#1, perms, G847, 9/2/05 11

Tuneral Director Society Number So		
Continued Cont		3. Time of Death
Examiner		7:58 P ^M
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Montgomery 10c. City, Town or Location 10c. City Code 10g. City 10c. Specify 10c. Sp	9. B (7959 Was	Birthplace (State or Foreign Country) Shington DC
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Solution of the street of the	et and Number or R State)	Rural Route Number,
	// /	29 20905
29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) A medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.	use s) and manner a le and place, and du	as stated. ue to the cause(s)
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dat		
29c. License number 29d. Dat O.C.M.E AUC	d. Date signed <i>(Mon</i> AUG 11, 2	
20 Carling.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21		
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State Registrar AUG 1 9 2005 State AUG 1 9 2005	21201	

State of Maryland / Department of Health and Mental Hygienes 1 - For Stete Registre 28980 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month **GUGUST** Merle Keith Hoskinson 17,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner S BAltimore 40SPITAL None If Under 1 Year | If Under 24 Hrs. | 8 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Sept 8, 1 9. Birthplace (State or Foreign Days Hours **№** M 2□ F Yrs Director 273 40 0186 58 1946 Ohio Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h Counts r then "natural", or Items 23a or 28a-f show the Medical Exemple: must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6008 Harford Avenue 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other then "natural", or Itel 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Health & Safety Maint. Officer Bowles Fluidics Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harold Hoskinson Gertrude Imogene Bonham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depirtment of Health and Important: If item 27 Is m any njury or other treum once. Kay Hoskinson/Sister 6008 Harford Avenue Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-22-2005 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MULTISKSTEM FAILURE disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner SEPS15 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit DNEUMONIA WEEKS that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medicai ARONIC DESTEUDINE PLLMONARY DISEASE YEARS the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BUCMONARY TUBERCULOSIS 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \[\subseteq \text{No} \] PNEUMOTHORAX autopsy performed? PERFORATED GASTRIC ULCER Yes 2 🗆 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 20 No After this 28a. Date o Injury (Month, Day Year) 27. Manner of Dear 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of sxamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shelulla 00037359 AUGUST 18,2005 Name and address of person with the state of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20,86. 900CATON AVE BALTIMORE, MOSIZZ9 31. Date filed (Month, Day, Year) istrar's Signature Registrar

			1 - For State Registrer	State of M	aryland		artment tificate				ental Hy	gien Reg. N	20	05	28	981
	Physici		1. Decedent's Name (First, Middle, I Dorothy G. Ha:	*							2. Date of De	eath P	ay_	Year	3. Time	of Death
	/Medi Examir		4a. Facility Name (If not institution, g)		4b. City,	Fown, or	Location	of Death	_00_	40	Count	y of Death	111,	00'
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	Funeral Director		5. Social Security Number 6. 234–42–9934	.Sex 7.Ag 1 ☐ M 2 ☑ F	ge (In yrs. las 74	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Day May 2,	th ay, Year 193	4	9. Birthi	place (State intry)	or Foreign
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	with the	Director	10e. Street and Number Rt. 4, Box 214				10f. Zip	Code 5726					itizen of	What Cou	ntry?	
	death rms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Deced	ent of His	panic Ori	igin? (Spe	cify Yes or No				can Indian,	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-1 show ha Midfeal Examilian mat be mailfied at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 1 Yes, Give Year or Dates:		i i	iYes,spec I□Yes 2		Specify:		Rican, etc.)		Specif	rck, White,		
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	and 2 si lealth an m 27 Is r her treur		Arthur Hartman,								Route Number			, State, Zip	Code)	
Baltimore,	- I O =		20a. Method of Disposition 1 Rurial 2 Cremation 3	☐Removal from State	20b. Plac	e of Dispos etery, crem	sition (Nam natory or oti	e of her place)	Da	ate	20c. L	ocation	- City or To	own, State	
Iţi m	Pa ant ury		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	cify)	Que	en's I					1/05	Ke:	yser	, WV		
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			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused y one cause on each li	d the death.	Do not ente	er the mode	of dying,	such as	cardiac or	respiratory a	Z6 / rrest,	26		Approxima Interval Be	ate etween
8	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a \	AULT	IPL	E	MY	210	MA				- 3	Onset and	
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NI'	Pa its	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):										
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9		/Med	IF FEMALE:	22a If you gutaama	of program									1		
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P. O.	that the de led by the a detached f	phys	9 Unknown	9□ Unknown												
Records,	sign sign d be	by	Part II. Other significent conditions	contributing to death b	ut not resultin	ng in the un	derlying ca	use given	in Part I.			obacco (Yes 2			ne cause of pably 4	
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Division of	Attend death ctor: /	Certification:	2 Accident investigate 3 Suicide 6 Could not determine	be 280 Blood of Inju	ury - At home	e, farm, stre	M et. factory.		es 2 🗆 l	-	Bf. Location (S	Street an	nd Numt	er or Rura	/ Route Nu	mher
á	rs after rs after el Dire	Certi	4 Homicide determined	building, etc	c. (Specify)						City or Tox	vn, State)			
	To the Hospitel or Attending is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 ← Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	i examination	dge, death and/or inve	occurred at estigation, i	the time n my opir	, date and nion, deat	d place, ar th occurred	d due to the d d at the time,	cause(s) date and	and ma place,	anner as st and due to	ated. the cause(s)
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_	6		DR. QAMAR ZA	AMAN LO	a5 K	ent		lue	., C	umt	perla	od	m	0 2	1508	a
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 0 1	2005 32. Registra	ar's Signature		Valentine V						, , ,			
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	1 - For State Registrar		State of IVI	aryland / L	Certificate	of Health and		Reg. No.	05 289	382
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/Medical Examiner			re street and number)			vn, or Location of Dea		4c. County of		
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Funeral	5. Social Security		1971 M OF TE	ge (In yrs. last birt.	thday) If Under 1 Y Yrs. Months D	ear If Under 24 Hrs ays Hours Min	. (Month, Da	th ly, Year)	Birthplace (State or Country)	
tal Hygiene. d other then "natural", or items 23a or 28a-f show sevent, the Medical Examines must be notified at sevent. Be Completed by Funeral Director	216-49-1 Usual Residence	182	4	27	113.		4/18/7	8 \(\(\)C	Cheverly, Mo	d
Mo H	10a. State	10b. County		10c. City, Town					10d. Inside Cit	
Important: if item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	Md.	Prince	George's	Fo	orestville	<u> </u>			¥₹Yes	2 🗌 No
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even Be		e C. Arno	•			_	M. Ivory	, Maideir Sumame)	,	
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othe	20a. Method of Dis	sposition		20b. Place of	Disposition (Name or other	of l	Date		ity or Town, State	
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State of Maryland / Department of Health and Mental Hygien 2005 28983 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Marvin Hatfield Jarrell, Jr. 19:15 PM /Medical August 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 29, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Vear) 954 West Virginia XXM 2 F 51 Director 215-58-3727 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County fshow 10d. Inside City Limits Examination rest be notified at Director MD Harford Aberdeen 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 348 Stratford Avenue 230 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene. I Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No þ Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Maintanence Constar Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H 2 Marvin H. Jarrell, Sr. Mary L. Ratcliff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i Rachel D. Jarrell (Spouse) 348 Stratford Ave., Aberdeen, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F-Important: If ita any injury or ot once. 9/2/05 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metasta Priysician /Medical Examiner Sequentially list conditions, If any leading to mad all cause. Enter Underlying Cause (Disease or injury Due to (or as a consecuence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Be Completed Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No • 24a. Was an 1 Yes 2,2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this patient 2 ER/Outpatient 3 DOA Manner of Peath 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a To the Funaral D 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 49686949 30. Name and address of person who complete scause of death (Item 3a) (Type, Print) tyangual 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 2005 Registrar

			1 - For State Registrar		State of Ma	aryland / De _l	partment of ertificate of		Mental Hy	rgiene Reg. No 20	05	28984
	Physic /Medi		Decedent's Name (Fi Clarence	First, Middle, Last)		Jones			2. Date of De Month AUGUST	eath) 0°5′	3. Time of Death 0655 M
	Exami		4a. Facility Name (If not Memorial H		reet and number)		4b. City, Town, CUMBER	or Location of Dea	th	4c. County		1
	Funeral Director		5. Social Security Numb 214-30-962	6. Sex	4 200	e (In yrs. last birthda Yrs.	/) If Under 1 Year Months Days			3, 1931	9. Birthp Court	lace (State or Foreign
	faryland show	'n	Usual Residence of Dec 10a. State 10	b. County Allegany		10c. City, Town or	ocation berland				1	Od. Inside City Limits
	with the A a or 28a-1	Direct	10e. Street and Number	r	. CF		10f. Zip Code	24502		10g. Citizen of V		1 X Yes 2 □ No htry?
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Examinatings be notified at	Completed by Funeral Director	120001 An 11. Marital Status 1 □ Never Married	12	. Was Decedent I Armed Forces? 1 Yes 2 N		. Was Decedent of If Yes, specify Cui		Specify Yes or No to Rican, etc.)	D- 14. Rac Blac	e - Americ k, White,	
Maryland 21215-0036	72 hours a "natural", o	eted by	3X Widowed 4 ☐ 15. (Specify o	Divorced Decedent's Educa	Year or Dates:	16a. Dec	1 Yes 2 No	pation	rkina	Specify 16b. Kind of Bu	white	
d 212	2 should be filed within and Mental Hygiene. Is marked other than " aumatic avant, the Mar		Elementary/Secondar 12 17. Father's Name (Firs.		College (1-4or 5	///A	DO NOT use retire	əd)	me (First, Middle,	Tire Con		/
rylan	should be nd Mental marked o umatic ava	To Be	Edward	Jones	Print)	19h Ma	ing Address (Street	Violet	(Brehm)	Jones		
	1 and 2 s Health ar tem 27 ls		Genise Ac	dams	daugl	nter Cou	ing Address (Stree Intry Club osition (Name of	Road	Cumk	perland 20c. Location -	MD	21502
Baltimore,	Page nent c ant: If ary or		1 Signature Funera	remation 3 □Ren]Other <i>(Specify)</i>	noval from State	Zion Memo			8/30/2005	Cumbe	•	`MD
Ba	permit. Departr Imports any inju		23a. Paryl. Enter the di	MM j	tions that caused	the death. Do not el	2. Name and Addr Scarpe 108 Vir	ginia Avenu	e: Cumber	land, MD 2	21502	Approximate
k	Pnysician /Medical		shock, of heart fail Immediate Cause (Fina disease or condition resulting in death)		Uren		sonin				3	Interval Between Onset and Death
V	Examiner	ner	Sequentially list condition if any, leading to immediates. Enter Underlying Cause (Disease or injury)	ons, b.E	nd S	consulence of):	enal	Disea	se		3	months
90,	ificate be executed g physician and as the b_rial-transit	I Examine	Cause (Disease or injury that initiated events resulting in death) Last	C.	Due to (or as a	consequence of):						
x 68760,	n certificate to anding physic use as the b	/Medical	IF FEMALE:	d								
.O. Box	death e atte	Physiclan/M	in the past 12 mon 1 Yes 2 No 9 Unknown	nths?	. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y	•	23d. Date Mon	of deliver th l	y Day Year
rds, P	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Dther significant	t conditions contril	buting to death bu	t not resulting in the	ınderlying cause gı	ven in Part I.		obacco use contri		e cause of death?
Vital Records,		Completed							24a. Was autop	rmed? pi	or to com	sy findings available pletion of cause of
	Physician: The this certificate ral director, pag	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ▼No		pital:	2 - 2 - 5 - 6 - 6 - 6 - 6 - 6 - 6 - 6 - 6 - 6	at 30 004 Ott		th (Check only o	ne)		
Division of	Jing After fune	-	27. Manner of Death	Pending investigation	28a. Date of Injun (Month, Day	/ 28b. Time (of 28c. Injui	4 Nursing H	ome 5 ☐ Resid 28d. Describe h	lence 6 Othe		
Divis		Certification:	3 Suicide 6 [4 Homicide	Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, si (Specify)	reet, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rural	Route Number,
	To tha Hospital or At within 24 hours after of To tha Funeral Direct completely filled in by	Medical	one)	modical Cathing	an: To the best of On the basis of and manner stat	my knowledge, dea examination and/or in ed.	h occurred at the til vestigation, in my o	ne, date and place pinion, death occu	and due to the c rred at the time, c	cause(s) and man date and place, ar	ner as sta nd due to t	ted. he cause(s)
)	Vith Conf	2	29b. Signature and title of	of certifier Uan	am,	mp	29c. Licens	2540		29d. Date signed ugust 2 (
	5			an Lar	nm 9	00 Seto		e, Cur	perla	ind M	Dã	71502
	Sta Registra		31. Date filed (Month, Da	ay, Year) EP 0 6 20[32. Résistrai	's Signature	perte			1		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:48 PM 2005 DOROTHY ABARILLA JEWELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Lanham Doctor's Community Hospital Latinian If Under 14 Hrs. If Under 14 Hrs. Months Days Hours Min. Mar. 26, 19. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 210 F Yrs Maryland Director 90 218-20-0028 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Greenbelt Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 U.S.A. 53 M. Ridge Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 injury or other traumatic event, permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Crown William Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 12417 Sadler Lane, Bowie, Maryland Juanita V. Morgan, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/23/2005 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signature of Foperal Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Maryland 20731 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 weeks DNGESTIVE /Medical Due to (or as a consequence of): **Examiner** MYOCARDIAL INFARCTION week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed DRAUNAR Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai ears as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate leural 2 No 1 Yes 2 No 1 ☐ Yes funeral director, Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death after death 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel I Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier UD 1056 Kenilworth Ave, Suite #2600 Riverdale M.D. 20737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. M. DIN, M.D 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 2 2005 Registrar

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryl	and / Dep		lealth and		•	28986
*	Physic /Medi Exami	cal	Khalid 4a. Fecility Name (If not institution, give:	Javed		4b. City, Town, o	or Location of Deat	August 18	Day Year , 2005	3. Time of Death 02: 59a M
	Funeral Director		081-88-5/00	7. Age (In)	vrs. last birthday) Yrs.	Takoma P If Under 1 Year Months Days				lace (State or Foreign
	th the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo 10e. Street and Number		City, Town or Lo			10g.	Citizen of What Cour	0d. Inside City Limits 1 ✓ Yes 2 ☐ No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury op	by Funeral	9100 Saint Andrews 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Place 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		20740 Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	akistan 14. Race - Americ Black, White, Specify:	etc.
1215-0	vithin 72 ho ne. hen "natur e Modical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of war	rking 16t	Asi b. Kind of Business/In	
Maryland 21215-0036	utd be filed w Aental Hygie rked other t tlc event, th	To Be Co	17. Father's Name (First, Middle, Last) Abdul Aziz	5	Rest	aurateur	18. Mother's Nar	ne (First, Middle, Mai	,	ce
e, Mary	and 2 shouselealth and No. m 27 is mailer treumail		19a. Informant's Name/Relationship (Type Ansar Choudhary Sc	n-in-Law	9100 Colle	Saint And Je Park	and Number or Ru	ral Route Number, Ci	ity or Town, State, Zip	Code)
altımore,	nit. Pages 1 artment of H ortent: If ite injury or at		20a. Method of Disposition 1	emoval from State Ma	morial	natory or other place National Park Name and Addre	Aug.	19,2005 La	urel, Mar	land
Ba	Department of the policy of th		23a, Park, Enter the disease, or compli	M00956 cations that caused the d	T 9	hibadeau 33 Gist <i>A</i>	Mortuary ve., LL,	Service, Silver Sp	P.A. oring, MD	Approximate
8/60,	Physician and // Medical Examiner prize pr	ical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	Infa	rction			Interval Between Onset and Death
O. Box oa	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3□	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ry Day Year
7	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions con	tributing to death but not i	resulting in the u	nderlying cause giv	en in Part I.		co use contribute to the	. 1
Vital Records,	The ate h page	Completed						24a. Was an autopsy performed	prior to cor death?	osy findings available inpletion of cause of
0	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	ıtlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. Injun World	er: 4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in	6 □Other (Specify)
UNISION	tal or Atter rs after dea el Director ed in by the	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streetify)			28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
	To the Hospital or Attendin \within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	Medical	29a. Certifier (Check only one) 2 Medical Examin 29b. Sigpature and title of certifier	er: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred at the tin vestigation, in my of	oinion, death occui	red at the time, date	e(s) and manner as stand place, and due to Date signed (Month, L	the cause(s)
	5		30. Name and address of person who cor	mpleted cause of death (I	M. P tem 23a) (Type,	Frint)	2326		8/18/	05
	Sta Registr		James K. Lightfoot, 31. Date filed (Month, Day, Year) AUG 19 2	32. R / istrar's Sig		ll Ave.,T	akoma Pa	rk, MD 20	912	

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 28987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 250 AM August Louise unda 17 200 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Months 1 M 2 XF Director Yrs. 217 86 7315 37 Sept 20, 1967 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23s 9978 Guilford Road Apt 204 20794 Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Int: If Itam 27 ie marked other then "naturel", or Itema 23 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Customer Service Rep. Foxfire Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ronald I. J. Champagne Gertrude V. Huffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita J. Mathur/Sister 7513 Montevideo Court Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) M01044 Meadowridge Cem. 8-20-2005 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Lung Cancer **Physician** METASTATIC smull /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes been si 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an paga 2 s autopsy cartificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this : After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Tes 2 No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mi reholus of death (Item 23a) (Type, Print) 4the PATERENT KK mis egistrar's Signat 31. Date filed (Month, Day, State Registrar

			1 - For Amend Item 25 Registrar	tate of M	rylansk	8 ,10 7	12705ahb tificate of l	ealth ar D <i>eath</i>	nd Mental Hy	giene Reg. No.	2005	28988
	Physici /Medi			ang					2. Date of D Month Augus	Day	200 ^{Year}	3. Time of Death a 11:40 M
	Examir		4a. Facility Name (If not institution, give stra 6911 Sandy Ridge Co				4b. City, Town, or Salisbu		Death		County of Death)
	Funeral Director		5. Social Security Number 488-80-7649 6. Sex	2□ F 7. Ag	e (In yrs. last 58	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B (Month, D	rth ay, Year) 1946		place (State or Foreign htry) h Korea
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico	•	10c. City, To	own or Lo				17.10		0d. Inside City Limits 1 XYes 2 □ No
	th with the I 23e or 28a-	al Director	10e. Street and Number 6911 Sandy Ridge Co		Darri	Sour y	10f. Zip Code	21804			zen of What Cour	ntry?
980	72 hours after death with the Maryland naturel", or Items 23e or 28e-f show dical Examinar must be notified at	by Funeral	11. Marital Status 12. 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cubar ☐ Yes 28 No	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Americ Black, White, Specify: KO	ean Indian, etc. Cean
Maryland 21215-0036	within ane. then "	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	ion o <i>mpleted)</i> Coll ege (1-4or 5	i+)	(Give i life. D	ent's Usual Occupa kind of work done of O NOT use retired,	ution uring most of	f working	16b. Kir	nd of Business/Ind	dustry
land 2	should be filed withind Mental Hygiene. s marked other ther umatic event, the M	To Be Co	12 17. Father's Name (First, Middle, Last) Soo Won Kang			DITTE	penuer		Name (First, Middle	, Maiden .	Hotel Sumame)	
	12 - 12 - 12 - 12 - 12 - 12 - 12 - 12 -		19a. Informant's Name/Relationship (Type) Pok Nam Kang/wife	Print)	1				or Rural Route Numb			
Baltimore,	of t		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Rem 1 □ Donation 5 □ Other (Specify)	oval from State	ceme	sbury	ratory or other place Cremator	y 8,	/20/05	Sali	sbury, M	iwn, State
Bal	permit. Pag Department Importent: I any injury o		21. Signature of Fugeral Service Licensee Muchuel A De	an			1 Snow H	ill Rd	Home Pro	ry.	onal Ass MD 21804	sociation
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only one disease or condition resulting in death) Sequentially list conditions,	ions that caused ause on each lir	tatic	(0/0	000	n, such as car		rrest,	0	Approximate Interval Batween Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Find underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a								
O. Box 68	death certifi e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)			2:	3d. Date of delive Month	ry Day Year
rds, P.	sign d be	by	Part II. Other significant conditions contrib	outing to death bu	ut not resulting	g in the un	derlying cause give	n in Part I.	23e. Did		1	e cause of death?
of Vital Record	The law ate has b page 2 si	Completed							24a. Was auto perfo 1 Ves		prior to con death?	osy findings available inpletion of cause of
on of Vita	iding Physicien: Th th. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending Accident investigation	pital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day		Outpatient D. Time of Injury	28c. Injury Work	r: 4 🗌 Nursir	Death (Check only on the control of	dence 6)
Division	al or Attending s after death. Il Director: After id in by the funer	Certification;	2 Cuiside 6 Could not be	28e. Place of Inju building, etc	iry - At home, c. (Specify)	farm, stre			28f. Location (City or To		Number or Rura	Route Number,
	To the Hospital or Attenwill in 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) Certifying Physici 2 Medical Examiner	an: To the best of On the basis of and manner sta	examination.	lge, death and/or inve	occurred at the time estigation, in my op	e, date and p inion, death o	lace, and due to the occurred at the time,	cause(s) a date and p	and manner as str place, and due to	ated. the cause(s)
•	To the within 2 To the complete	2	29b. Signature and title of certifier	DM)		29c. License	number 627	8	29d. Date	signed (Month, L	19/2005
	100	ij	30. Name and address of person who comp	CorsTA	L 46 PI	CE=	P.O. B.	173	3 50/	si _	1-10	21802
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 2 3 200	32. gistra	r's Signature	4	all)′	

State of Maryland / Department of Health and Mental Hygien 200528989 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Clara Bell Korrell August 19 2005 3:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Hlth Care Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | June 27, 1917 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F 217-46-2761 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28a-f show other treumatic event, the Medical Evant retinual by retiliad at 1 XYes 2 □ No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 St. Luke Circle 21158 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Martin Huebner Jenny Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert B. Korrell/son 4361 Baughman Mill Rd. Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages to Department of Himportent: If ite any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Garden 8/22/2005 Marriottsville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service icensee 22. Name and Address of Facility nothers Hartzler Funeral Home 310 Church St. New Windsor, Md. 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Asperation Preumania disease or condition resulting in death) /Medical Due to (o as a consequence of): Examiner Atzheumenz Dementra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician a for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Avatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attenc within 24 hours after death To the Funerel Director: 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: On the basis of examination in or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aug. 2157 2005. WJL D37949 ted cause of death (test) 23a) (Type, Print) 10 30. Name and address - rson who Ale south PostachersCylus
31. Date filed (Month, Day, Year)
32. Regightar's Signature 2 Lorantheme, Westminister, MUD, 21157 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygien 2005 28990 1 - For State Registrat Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Amelia Saline Bassey Kollie August 14 <u> 20</u>05 7:47 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F 66 216-49-8575 Director April 21,1939 Liberia Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13417 Queenstown Lane 20874 Funerai Liberia 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Year or Dates: **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Bassey Julia Unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mildred Daniels / Daughter 13417 Queenstown Lane, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery August 27 * 4 □Donation 5 □ Other (Specify) Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Licenses Deer Park Drive, Gaithersburg, MD 20877 RACO Thur 23a. Part1. Enter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Liver Failure /Medical Due to (or as a consequence of) Examiner Hemachromatosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical as the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à requires Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy rmed? 2X No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred s after death. Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I title of certifie 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D58681 August 15, 2005 nd address of person who completed cause of death (Item 23a) (Type, Priot) Jude R. Alexander, MD , 9901 Medical Center Drive, Rockville, MD 20850 ed (Month, Day, Year, 32. gistrar's Signatur Date fi State AUG Registra

HAROLD KALIN 05-05724 RJ

			For State of Maryland	/ Department of F Certificate of	lealth and M <i>Death</i>	lental Hygien Reg. N	2005	28991
			Decedent's Name (First, Middle, Last)			2. Date of Death	ou Va-s	3. Time of Death
	Physicia		HAROLD ROSS KALIN			August 24	ay Year 2005	3:32 p. M
	/Medic Examin	_	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death	4	c. County of Death	
	LAGITIST		Prince George's Hospital Center	Cheverl	.y	P	rince Ge	orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	it birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea.	9. Birth	nplace (State or Foreign untry)
	Director		084-26-7301 MAM ^{2□F} 71	Yrs. Moritins Days	Hours Willi.	FEB.16,1	934 NEV	YORK
	P .		Usuel Residence of Decedent	T				10d Inside City I imite
	nylar	_	10a. State 10b. County 10c. City,	Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☒No
	9 Mg	Director	MARYLAND CHARLES WAL	DORF				
	or 24		10e. Street and Number	10f. Zip Code		10g. C	Citizen of What Cou	intry?
	23e	100	12861 OWENS DRIVE	2060			U.S.7	
	r deg	Ine	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of F If Yes, specify Cub 	Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	72 hours after death with the Maryland natural, or items 23s or 28e-f ahow Alcal Examinat must be multified at	by Funeral	1 ☐ Never Married XTXMarried 1 ☐ Yes 2 ☐ No IIYes, Give 1 Year or Dates: USAF	1 ☐ Yes ŽŒNo	Specify:		Specify:	· ·
21215-0036	hour tural	d b		16a. Decedent's Usual Occup	nation	165	Kind of Business/l	HITE
쟌	n 72 "na	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind of work done life. DO NOT use retire	during most of work	ing	14.10 01 20011000	
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9	e filed Il Hygid other vant, II	Ö	17. Father's Name (First, Middle, Last)	MIN I MIN I TO I TO I TO I I		(First, Middle, Maide		30100
an	id be ental ked o	o Be	ROBERT ROSS KALIN		SYLVIA	BARBER		
<u>-</u>	2 shoul and Me is mark sumati	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	·		or Town, State, Z	ip Code)
Maryland	d 2 s lith ar 27 is 1 trau		HERB KALIN-BROTHER	12861 OWENS	DRIVE.	JAIDORF, M	IARYI.ANI	20602
<u>5</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23e or 28e-f ahow other traumatic avant, the Modical Examinant cavat be notified at		20a Method of Disposition 20b. Pla	ce of Disposition (Name of netery, crematory or other pla			Location - City or	
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		1	9 20 05	MATINE	N 15Th
章	ait. Pertme		21. Signature of Funeral Service Licensee MOO479	22. Name and Addre		0-29-03	WALDOKI	LA PAD
Ba	permit. Page Depertment of Important: If any injury or once.		my les			SERVICE,		
			23a. Part1. Enter the disease, or complications that caused the death.	Do not enter the mode of dy	ng, such as cardiac	ND 2064 or respiratory arrest,	16	Approximate Interval Between
			shock, or heart failure. List only one cause on each line.	, /				Onset and Death
1	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence)	Le / Muril	1			
	Examiner		Due to (or as a conseque	ince on).				
		-e	Sequentially list conditions, if any, leading to immediate	ned of).	-			
٧	t insit	든	causé. Enter Undertying Cause (Disease or injury that initiated events c.					
	exection ending	Examiner	resulting in death) Last Due to (or as a conseque	ence of):				
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Box	death certifi e ettending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal of				23d. Date of deli	
m.		Cla	in the past 12 months? 4 Pregnant at time of dea				Month	Day Year
0	at the de by the o	hys	9 Unknown 9 Unknown					
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Record	s been s been s shoul	ompleted				24a. Was an	24b. Were au	topsy findings available
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Vital		O	25. Was case referred to medical		26. Place of Deat	h (Check only one)		
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of		l ii		28b. Time of 28c. Inju	ry at	28d. Describe how in	jury occurred \$	whit chier q
Division	= -₹≥	atlo	1 Natural 5 Pending 2 Accident investigation		Yes 2 No	which in	which	accident
Vis	l or Attend efter death Director:	=======================================	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or, Ru	ral Route Number,
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	tha H in 24 ha F plete	edical	one) and manner stated.					
	To the twithin 2. To the complet	Σ	29b. Signature and title of certifier		se number		Date signed (Monti	
			7 hushow bl. Keng in	OCMI	<u></u>	Au	igust 25,	2005
	() 1. I		30. Name and address of person who completed cause of death (Item:	23a) (Type, Print) Pont	Street	Baltimore,	Marralan	d 21201
	441		THE DOONE MIKYLIC		. DITECT		, rarytan	
		ate	31. Date filed (Month, Day, Year)	le freele				
	Regist	rar	SEP 0 1 2005 Been 1					

			1 - For State Registrar	State of Maryland	/ Depa	artment of H tificate of L	ealth and Death	Mental Hyg	Jiene Jeg. No. 200	15	28992
ı	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day V	ear	3. Time of Death
	/Medi	čal	JoAnn	Lewis					14, 2005		03:48 a ^M
	Examir	er	4a. Facility Name (If not institution, give s Washington Advent			4b. City, Town, or Takoma		th	4c. County of I		
	Funeral		5. Social Security Number 6. Sex		birthdav)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Montg		
	Director		578-66-3112	M 2⊠F 56	Yrs.	Months Days	Hours Min		Year)		ace (State or Foreign ry) rgia
	pu ,		Usual Residence of Decedent	140 00					. , 25 (5		- 8-4
	anyla shov	2	10a. State 10b. County	10c. City, T						10	d. Inside City Limits
	the M	ecto	MD Prince Ge	orges	Rive	rdale			·		1 Yes 2 No
	with Sa or	급	6008 Madison Stre	a+		10f. Zip Code	1727	1	0g. Citizen of Wha	t Count	ry?
	death	Funeral Director		2. Was Decedent Ever in U.S.	13. V		0737 Spanic Origin? (5	Specify Yes or No-	USA 14. Race - /	America	n Indian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examination until conditional	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2☑ No	Specify:	to Rican, etc.)	Black, V	White, e	
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Maryland	d be funtal h	Be	Willie C. Lewis					me (First, Middle,) Hester	Maiden Sumame)		
<u> </u>	should nd Me mark mati	2	19a. Informant's Name/Relationship (Typ	ne Print)	9h Mailin	g Address (Street a			City or Town Sto	to 71- (7- del
Š	nd 2 still ar ar ar ar ar ar ar		Brian M. Sam/Son			Fox Park		inton, M		1 0 , ZIP C	2000)
re,	s 1 a of Hez itam othe		20a. Method of Disposition	20b. Place		sition (Name of natory or other place			20c. Location - City	y or Tow	m, State
altimore,	Page nent c int: If iry or		1 ☑8urial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	silioval itulii State		Cemetery		2-2005	Washingto	on.	DC
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service License	116 000	22. M	Name and Address arshall s 217 9th S	of Facility Funera	1 Home,]			
	76		23a. Party Enter the disease, or complic shock, or heart failure. List only one	eations that caused the death. I							Approximate
. 1	Physician	10	Immediate Cause (Final disease or condition	South	1 1	ck					nterval Between Onset and Death
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	edical	29a. Certifier 12 Certifying Physic (Check only one) 2 Medicel Exemine	cian: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death and/or inve	occurred at the time estigation, in my opin	, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and manner te and place, and o	as stat	ed. ne cause(s)
	To t withi To tl	Ž	29b. Signature and title of certifier			29c. License i	number	29	d. Date signed (Mo	onth, Da	ıy. Year)
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2	(6)		30. Name and address of person who com	pleted cause of death (Item 23a	i) (Type, P	rint)	hinel	on A	dvinh	17	Hose
	Sta Registra		31. Date filed (Morfet), Day, Year) AUG 1 9 2005	\$2. Registrar's Signature	hour	?	1			-/- (-	1147

State of Maryland / Department of Health and Mental Hygiens 28993 1 - For Stete Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2005 JOSEPH HYMAN LISS August 19 3:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1801 E. Jefferson St #502 Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 88 Months Days Hours 1 □ xm 2 □ F Director 092-03-7289 July 24 1917 Bronx, NY Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County ms 23a or 28a-f show 10d. Inside City Limits Directo 1 ☐ Yes 2x No Rockville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1801 East Jefferson Street #502 20852 United States or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status injury enother traumatic event, the Medical Examiner 1 Tayes 2 No WWII
If Yes, Give
Year or Dates: Army within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. I othar than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner/Salesman Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If itam 27 is marked of Abraham Isaac Liss Mary Alefsky ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8315 North Brook Lane #207 Bethesda, MD 20814 Marsha Liss, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Saurial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐Donation 5 ☐ Other (Specify) Judean Mem. Gardens | 08-22-2005 Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. any ir 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Renal Failure /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Chronic Liver Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊋Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Stroke 2 🗌 No 1 Yes 2X No 1 TYes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🙀 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To tha Funaral C

completely filled filled 29a. Certifier 1🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 35436 August 20, 2005 awale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road Rockville MD 20852 Barbara Kalazny, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 22 2005 Registrar

Albert Luther Liebno, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-05534 State of Maryland / Department of Health and Mental Hygiene, crn For State Registrar 289**9**4 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician ALBERT LUTHER LIEBNO, SR. 2005 12:35 A 16 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2311 Bear Run Road Taneytown

If Under 1 Year | If Under 24 Hrs. Carroll 8. Date of Birth (Month, Day, Year) 1 / 27 / 1931 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**∑**M 2□ F Yrs 74 217-36-4956 Director MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner rount be notified at 1 ☐ Yes 2X No Completed by Funeral Director MD TANEYTOWN CARROLL 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number 21787 2311 BEAR RUN RD. USA 238 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, elc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE FARMER 6 Pages 1 and 2 should be filed vitnent of Heelth and Mental Hygie tent: if item 27 is marked other tury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARGARET R.C. FISHPAW HENRY J. LIEBNO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY A. LIEBNO - WIFE 2311 BEAR RUN RD., TANEYTOWN, MD. 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. LORRAINE PARK CEM. 8/18/05 BALTIMORE, MD. Donation 5 ☐ Other (Specify) 21. Signature of Formal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) **Physician** Contact shotgun wurund /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dinknown 23e. Did tobacco use conInbule to the cause of death? Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death? 1 X Yes 2 No 1 Yes 2 🗆 No Division of Vital Physician: 25. Was case referred to medical examiner?

† Yes 2 No 26. Place of Death (Check only one) Be at scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence ို 6 Other (Specify) this 28a. Date of Injury
Found (Month, Day Year) After this 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury al Work? Certification: subject shed 1 Natural 5 Pending Feurn IZ ID AM 1 Yes 2 No investigation 8/16/05 SLH 2 Accident 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 23il Bour Run Rd. 3 Suicide 4 Homicide 6 ☐ Could not be determined seene laneybron, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL O.C.M.E. August 16, 2005 southall, mi) 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 tamela E. Southall, mi 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			1 - For State Registrar	te of Maryland /	Depa <i>Cer</i>	rtment of F tificate of i	lealth and I <i>Death</i>		giene 0	05	28996
	Physici /Medic		Decedent's Name (First, Middle, Last) Eve	lyn LAZER				2. Date of Dea Month August		Year 5	3. Time of Death
)	Examin		4a. Facility Name (If not institution, give street and Heritage Harbour Nurs	ing Home		Annap			4c. County Anne		le1
L	Funeral Director		5. Social Security Number 6. Sex 213-44-2801 1 M 2	7. Age (In yrs. last)	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 15	, Year) , 1915	9. Birtho Coup Wash	place (State or Foreign http) nington, DC
	Aaryland I show	or	10a. State 10b. County	10c. City, To						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h the N or 28a-	lrect	Maryland Anne Arundel 10e. Street and Number	. EC	lgewa	10f. Zip Code			10g. Citizen of	What Cour	
	s 23a c	raiD	1633 Midland Road			210			United	Stat	es
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumetic event. It Medic Exertili etc. ust be rediffed at once.	by Funeral	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces? Yes 2 XNo es, Give ar or Dates:	1	/as Decedent of H Yes, specify Cuba □ Yes 2(X)No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	1	se - Americ ck, White, $_{V}$: whi	
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give I	ent's Usual Occupation of work done of NOT use retired	during most of wor	king	16b. Kind of B	usiness/In	dustry
212	d withii giene. er then	Somp	Elementary/Secondary (0-12) Co	lege (1-4or 5+)		maker			Own H	ome	
and	d be file	Be (17. Father's Name (First, Middle, Last) Morris Fleishman					ne <i>(First, Middl</i> e, da F i nn	Maiden Suman	ne)	
Maryland	nd 2 should Ith and Me 27 is mark treumetic	To	19a. Informant's Name/Relationship (Type, Pri Raymond Lazer, Son	nt) 15	9b. Mailing	Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, MD 210		Code)
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remova 1 □ Donation 5 □ Other (Specify)	from State ceme	tery, crem	ition (Name of atory or other plac morial G	. 1007	Date 19/05	20c. Location -		wn, State
Balti	permit. Departn Importe any injt.		21. Signature of Fundral Service Linear	3		Name and Address rchinsky 4 Carrol				DC 2	20012
68760,	Medical Examiner and physician and physician street is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	that caused the death. Dee on each line. The to (or as a consequence up to	e of):	the mode of dying		or respiratory arr	est,		Approximate Interval Between Onset and Death
O. Box	the death certific by the attending p ached for use as I	Physician/Mec	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			23d. Dat	e of delive	ry Day Year
Vital Records, P.	Physicien: The law requires that the death certificate be executed in this certificate has been signed by the attending physician and arai director, page 2 should be detached for use as the buriat-transit	e Completed by Pl	Part II. Other significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions conditio	g to death but not resulting Sufficiently Control Cont	in the no	derlying cause give	es by	1 Yes 2	n 24b. V	3 Prob	e cause of death? abiy 4 Unknown by findings available inpletion of cause of 2 No
	hysicie nis cert I direct	To B	examiner? 1 Yes 2 Hospital	1 Inpatient 2 ERV		3□ DOA Othe		th <i>(Check only on</i> ome 5 \subseteq Reside		er (Specify)
Division of	nding Plath. r: After the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b	. Time of Injury	28c. Injury Work M 1 🗀 Y	at	28d. Describe ho			
Divis	tal or Atters after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number, State)	er or Rurai	Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, p.	Medical		To the best of my knowledge the basis of examination of manner stated.	ge, death and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	ause(s) and ma ate and place, a	nner as sta	ated. the cause(s)
)	1/2	~	29b. Signature and title of a differ	eX	W)	29c. License		7	9d. Date signed	Month, L	Day, Year)
			30. Name and address of person who complete	West Dr) (Type, P	(H /U	UETha	Na ide Ud	lochi,	1.D.	2_
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 9 2005	37 Aegistrar's Signature	400	els))			

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shock or heart failure. List only one cause on each line. Physician / Medical Examiner	ă	E G G G		Veni Collis-	With						City,	MD 21043
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State Registrar AUG 272 2005	3				32. Pegistrar's Signa	ture /	hastes	. 31. 1	1111100004	IVY Y	THE W	- V- V - /

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State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Walter Louis Lohfeld 1:20 PM /Medical 2005 tugust 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Community Hospital Prince Georges Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 10**X**M 2□ F Director 84 Yrs 154-01-9599 06/30/1921 New Jersey Usual Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location ortent; If item 27 is marked other then "naturel", or items 23a or 28a-f show injury or other treumetic event. It a Modical Examinator rust be notified at 10d. Inside City Limits Directo Maryland Prince Georges 1 Yes 2 □ No New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6013 Westbrook Drive 20784 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 142-145 Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Director of the
Audit Division 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene Importent: If item 27 Is marked other then "ranging yor other treumetic auchst General Elementary/Secondary (0-12) College (1-4or 5+) Accounting Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Lohfeld Beatrice Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie G. Lohfeld/ Wife 6013 Westbrook Drive New Carrollton, MD 20784 20b. Place of Disposition (Name of cometery, crematory or other place)
Parklawn
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 08/20/2005 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Ulan friet. 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Shock /Medical Due to (or as a consequence of): **Examiner** n Sequentially list conditions, if any, leading to immediate cause. En of line dry to Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): physician Box 68760 Physiclan/Medlcal the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No from wagulo pathy AND Thrombucytope NAT Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely i (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 1)20633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILHELMINA MCRUZ DRS Hospital 8114 Good Luck Rd 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State n & April Registrar

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day <u>1:2</u>0 ^a м Montes de Oca, Sr. August 19, 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 10900 Hobson Street Kensington
If Under 1 Year If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☑ M 2 ☐ F Months Min. Director 578**-**56-0512 71 Jan. 16. 1934 Guatemala Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits The Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 10900 Hobson Street 20895 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 28 Married 0 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced "natura!", Guatemalan White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. General Contractor Construction permit. Pages 1 end 2 should be file
Department of Health and Mental Hy
Important: if Item 27 is marked oth
any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Montes de Oca Guadalupe Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Shirley M. Montes de Oca 10900 Hobson Street Kensington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Aug. 21, 2005 Alexandria, Virginia Crematory 21. Signature of Funeral Service Lies see Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure days /Medical Due to (or as a consequence of): Examiner Acute Renal Failure weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Sit physician and is the burial-trans Coronar Arter Disease vears Due to (or as a consequence of): Box 68760 Physician/Medicai Hypertension vears attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy performe 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2X No After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation aspital c.
4 hours after dea...
rai Director: Afr 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) atzon MD 40596 August 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramin Oskoui, M.D. 3301 New Mexico Avenue, NW #316 Washington, DC 20016 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2005

State of Maryland / Department of Health and Mental Hygiene 29000 State Registrar AMEND Item #19a Per FH G857 Certificate of Peath Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wallace Minke Raymond /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner If Under 24 B. Date of Birth (Month, Day, May 14, 5. Social Security Number 7. Age (In vrs. last birthday If I Inde 9. Birthplace (State or Foreign 6. Sex **Funeral** 1**∑**M 2□F Yrs า๊921 МĎ 215-12-2268 Director 84 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinational by molified at MD n/a Baltimore 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4100 North Charles Street 21222 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) it. Pages 1 and 2 shows intention of Health and Mental Hygiene ortant: If item 27 is marked other thr Management B&O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond J. Minke Emma R. (Sturtz) Minke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 967 Chestnut Ridge Rd. Morgantown WV 26505 Joan Allender /sister daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Depertment of important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State Scarpelli Funeral Home, P.A. 8/29/2005 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA once 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. 23a Part Immediate Cause (Final disease or condition resulting in death) EDEMA Physician ULMONARY HOUR /Medical Due to (or as a consequence of) Examiner OBSTRUCTIVE AIRWAY DISEASE HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner ARTERY DISEASE burial-transit ORONARY The law requires that the death certificate be execu Due to (or as a consequence of RHEIMER'S DEMENTIA Box 68760, physiclen the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 2 No 1 Tes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 1 Tes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3X DOA 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Fafter death. After 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) in by determined 4 Homicide filled To the Hospital within 24 hours 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Grantsville, MO SABAha NAWAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

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